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S. Hrg. 111–36

YOUTH SUICIDE IN INDIAN COUNTRY

HEARING

BEFORE THE

COMMITTEE ON INDIAN AFFAIRS
UNITED STATES SENATE

ONE HUNDRED ELEVENTH CONGRESS

FIRST SESSION

FEBRUARY 26, 2009

Printed for the use of the Committee on Indian Affairs

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YOUTH SUICIDE IN INDIAN COUNTRY

THURSDAY, FEBRUARY 26, 2009

U.S. SENATE,
COMMITTEE ON INDIAN AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 10 o'clock a.m. in room 628, Dirksen Senate Office Building, Hon. Byron L. Dorgan, Chairman of the Committee, presiding.

OPENING STATEMENT OF HON. BYRON L. DORGAN, U.S. SENATOR FROM NORTH DAKOTA

The CHAIRMAN. I will call the hearing to order. This is a hearing of the Indian Affairs Committee of the United States Senate. The subject of the hearing today is an oversight hearing on youth suicide in Indian Country.

I have an opening statement. I think I will just simply make a couple of comments and then call on Vice Chairman Barrasso for a couple of opening comments. Our Senate Majority Leader is here as our first witness, and I want to get right to him.

I want to make just a couple of brief comments about this subject. It is a very sensitive subject. I have held a couple of hearings on it, one in North Dakota where we had a cluster of teen suicides on the Standing Rock Sioux Tribe Reservation. I held a hearing here in Washington, D.C. on it. I acknowledged when I held the hearing that this is a very sensitive subject, a very difficult subject.

I have told the story on the floor of the United States Senate, with the consent of the relatives, of a young woman named Avis Little Wind. Avis was 14 when she died. Avis Little Wind apparently felt hopeless and helpless and took her own life. She laid in a bed at home for some 90 days in a fetal position and nobody asked about her. Somehow she was never missed. Her sister had committed suicide. Her mother was a drug abuser. Her father had taken his own life. And somehow she just fell through the cracks.

Avis Little Wind was just a 14 year old girl who ended her life very early. I went to that reservation. I met with the tribal council. I met with school officials. I met with her classmates. I was just trying to understand what is happening and why. What causes this?

Following that, and following discussions at the Standing Rock Reservation where I went and met just myself with a good number of high school students to talk to them about their lives, we put together some legislation to try to make mental health treatment and counseling more widely and readily available to young people

on Indian reservations, to try to, as one response, address some of the issue of teen suicides.

Today, we will hear about what those efforts have resulted in. We are going to hear from a good number of witnesses. We are going to hear from Dana Lee Jetty, who is a student at Minnewaukan Public School and a member of the Spirit Lake Dakotah Nation. Dana's sister took her life. Her parents are with us today.

We want to hear testimony from a number of members of other tribes. We are going to hear testimony from the Director of the Indian Health Service and the Acting Administrator of the Substance Abuse and Mental Health Services over at the Department of Health and Human Services.

I want to mention we have a vote that will occur at 10:30 a.m., so we will recess for the vote today. After I call on Vice Chairman Barrasso for a couple of comments, I am going to call on our Majority Leader. We are enormously honored that he has joined us today to be the lead-off witness on this very important subject.

PREPARED STATEMENT OF HON. BYRON L. DORGAN,
U.S. SENATOR FROM NORTH DAKOTA

Today, we will hold an oversight hearing on Youth Suicide in Indian Country. The purpose of today's hearing is to examine the effectiveness of the current prevention programs in Indian Country.

The issue of suicide is of great importance both to this Committee and to me personally. As someone who has felt the crushing blow of suicide by a friend and coworker, I am aware of the tremendous effect suicide has on surviving family members, friends and a community.

Indian Country suffers from many health and economic disparities that have been linked to a higher risk of suicide: alcohol and substance abuse, depression and mental illness, unemployment, and domestic violence.

The broken health care system in Indian Country adds to the risk of suicide in American Indian communities.

The unfortunate result is that the rate of suicide among American Indian and Alaska Natives is 70 percent higher than the general U.S. population.

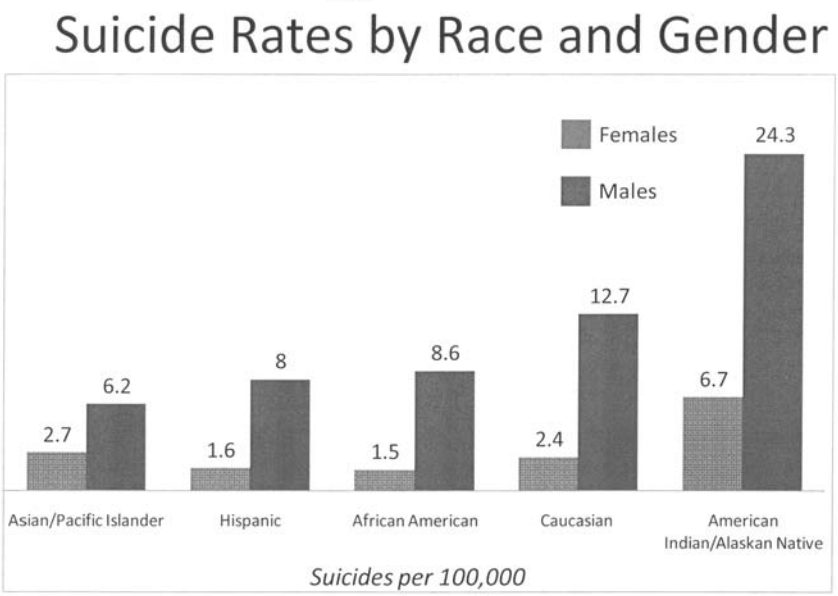
Today, we are focused on our young people in Indian Country and sadly they are not spared from these trends. **[Chart 1]** In this chart, we have listed on the left the 10 states with the highest percentage of Indians and on the right the 10 states with the highest rates of youth suicide. As you can see, the correlation is very troublesome.

Chart 1

Source: United States Census, www.census.gov/population/estimates/state/rank/aiea.txt, and CDC's WISQARS website "Fatal Injury Reports", www.cdc.gov/ncipc/wisqars

[Chart 2] This next chart shows the rates of suicide for ages 10 to 24 across numerous racial groups. As you can see, American Indian and Alaska Native youth have the highest rate of suicide for both males and females. Young American Indian men have a suicide rate 2 to 4 times higher than adolescent males and 11 times higher than same-age females in other racial groups.

Chart 2

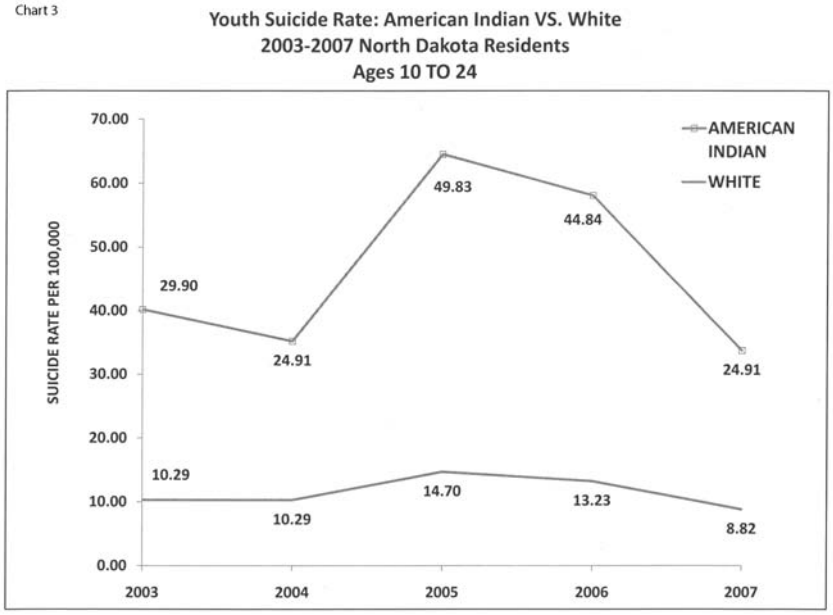


Source: National Adolescent Health Information Center, 2006 Fact Sheet on Suicide: Adolescents & Youth Adults

In the last decade, Indian Reservations have seen youth suicide rates reach epidemic levels. In 2005, there were youth suicide clusters on the Standing Rock, Crow Creek and Cheyenne River Reservations. This is a crisis that we must address.

I want to show a chart **[Chart 3]** which depicts the disparity in youth suicide rates from my home state. The top line shows the rate of suicide for American Indians, ages 10 to 24. The bottom line shows the same for Caucasians. Again, the rate for American Indians is incredibly high, but it also shows a decline over the past two years.

Chart 3



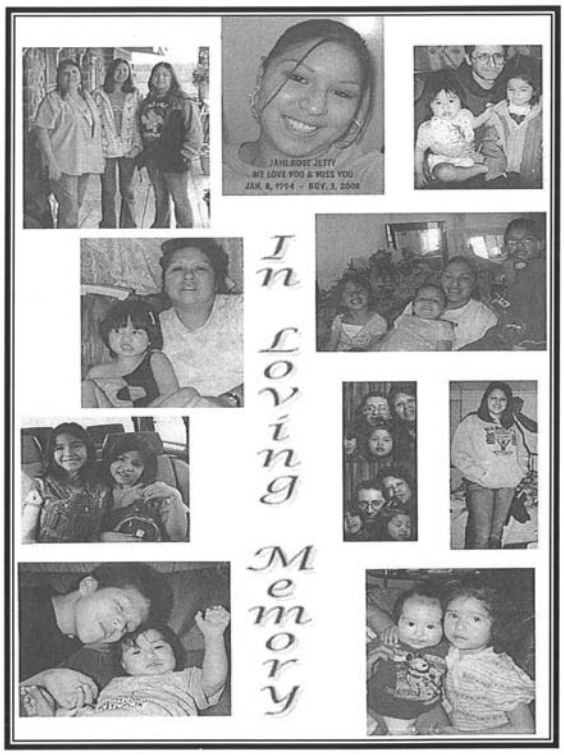
Source: North Dakota Department of Health, Division of Vital Records

In response to the epidemic in 2005, the issue of youth suicide in Indian Country gained National attention. Agencies, like the Substance Abuse and Mental Health Services Administration and the Indian Health Service, began specific initiatives to deal with the crisis. New grant funding, like the Garrett Lee Smith grants, were available for youth suicide prevention and many Tribal communities have received funding for their own programs.

This Committee held three hearings on youth suicide in 2005 and 2006. Part of what we are doing today is to follow-up on youth suicide prevention efforts that have occurred since our last hearing.

We will receive an update from the federal agencies responsible for administering youth suicide programs, experts on the issue and Tribal leaders who see the impact of youth suicide every day. We will also be hearing from a longtime advocate for suicide prevention, the honorable Majority Leader Reid.

I want to end my statement by saying, one youth suicide is one tragedy too many. This issue is about more than numbers, it is about the families and communities left behind and the young lives we have lost. **[Chart 4]** I want to show you see the face of a beautiful young woman, Jami, from the Spirit Lake Nation in my home state of North Dakota. Last November, Jami felt hopeless and decided to take her own life. Today, her sister, Dana will tell us, on a personal level, what youth suicide really means for Indian Country. We all need to work to address this crisis.



I want to thank all the witnesses for being here today and look forward to your testimony.

Senator Barrasso?

STATEMENT OF HON. JOHN BARRASSO,
U.S. SENATOR FROM WYOMING

Senator BARRASSO. Well, thank you, Mr. Chairman. Like you, I have an opening statement, and it is an honor to have Senator Reid here, so I will submit my opening statement to the record.

But I just want to say that no community is, or ever will be, immune from the tragedy of suicide. We have to make sure that the trauma of suicide and its aftermath does not paralyze the community. With that, I would like for just a few seconds, Mr. Chairman, to talk about the Wind River Indian Reservation in Wyoming, home of the Eastern Shoshone and the Northern Arapaho Tribes. It serves as an example.

You talked about how serious and how sensitive this issue is. In two short months a number of years ago, nine young Native American men between the ages of 15 and 25 committed suicide, with another 88 verifiable suicide attempts occurring on the reservation within that time frame.

Mr. Chairman, the Wind River Indian community mobilized to address this crisis, creating a team that included that Bureau of Indian Affairs, the Indian Health Service personnel, as well as the

traditional and tribal leaders. Mr. Chairman, the suicides and the suicide attempts soon subsided. Since that time, the number of youth suicides has been decreasing on the reservation.

So I am particularly pleased that the Northern Arapaho suicide prevention team works well with the Fremont County Suicide Prevention Task Force and know that there are solutions and we can find them. Working together, we can improve our efforts even more.

So with that, Mr. Chairman, let me just submit my statement to the record and welcome along with you, and say what an honor it is, for all of us to have Senator Reid with us this morning.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much.

I did not mention that the rate of suicide among American Indian and Alaska Natives is 70 percent higher than the general U.S. population. We have seen very troubling clusters of suicides, especially among Indian teens. That is what this hearing is about today.

Senator Reid, we are pleased that you are here. The presence of the Majority Leader is always an honor. I know that this issue is something that is very personal to you and that you have spent significant time working on it as well.

Thank you for being here, and you may proceed.

STATEMENT OF HON. HARRY REID,
U.S. SENATOR FROM NEVADA

Senator REID. Chairman Dorgan, Dr. Barrasso, it really is a pleasure for me to be here today. I appreciate your holding the hearing.

As Chairman Dorgan mentioned, this issue of suicide is very personal to me. More than a dozen years ago, I attended a Special Committee on Aging meeting chaired by Senator Bill Cohen from Maine. At the hearing, Mike Wallace talked about his emotional problems. This famous man, the anchor for 60 Minutes for so long, indicated that there were many times that he wanted to die. He would try to pick assignments hoping that maybe something would go wrong and he wouldn't be able to come back.

I was so impressed with his courage being there, his ability to speak publicly about a problem he had and the treatment he had received. Basically what he said was, "I don't have that problem anymore. I take a little bit of medicine, talk to somebody once in a while, and I am fine."

At that time I commended him for his speaking out publicly about a condition that some associate with weakness, that some people, and many feel frankly, is a stigma. It was during this hearing that I came to the conclusion that my own personal experience in dealing with my dad, is something that I should talk about publicly. I and my family had kind of kept it to ourselves. Had we really failed? Why did my dad shoot himself in the head with a pistol? The whole family, we just kind of, I guess, pretended it hadn't happened.

But at this hearing on Aging, I said that my dad had killed himself and that we should hold a hearing on senior suicide, and we did. I came to the realization that suicide was a national problem,

not my problem, not my family's problem, not Nevada's problem, but a national problem. I came to the realization that there were people that needed to be advised that they were not the cause of someone having killed themselves.

The people who survive a suicide are many times the victim themselves. Feelings of guilt persist. So following these hearings that Chairman Cohen was willing to have, I was contacted by a married couple from Georgia. There name was Weyrauch, Georgia and Elsie Weyrauch. They had lost an adult daughter, who was a physician. They were so proud of her. She got out of medical school and had a good, successful practice, but she killed herself. These two wonderful people founded the Suicide Prevention Advocacy Network to raise awareness about the issue.

So with their encouragement and that of a wonderful staff member of mine who became so involved in this, Jerry Reed, who since has left my office, and gone on to get a Ph.D. He has worked on suicide since those hearings that we had in the Aging Committee. He is here today, still working in suicide prevention.

With their support I proposed S. Res. 84, which declared suicide to be a national problem and sought to make suicide prevention a national priority. It passed the Senate. It passed the House. After Surgeon General David Satcher was confirmed, I invited him to approach suicide as a national public health issue, and he did. In 1998, he convened a conference in Reno, Nevada. The Reno conference brought together experts from all over the Country to address the problem of suicide. By the time they were finished, they had come up with a national strategy for suicide prevention.

There are so many interesting things about suicide. Why are the leading States of suicide west of the Mississippi? For those of us in the West, where the air is so clear and the sun is so bright, and we don't have the dark winters, why is that? We are trying to figure it out. We don't know even now. But Dr. Satcher's convening the conference gave the issue some momentum. In 2001, a couple of years after that, the United States Department of Health and Human Services published its national strategy for suicide prevention, which provides a blueprint for suicide prevention in the United States. In 2002, a year later, the Institute of Medicine published its report, Reducing Suicide: A National Imperative.

Now, Committee members, there had been nothing done about suicide prior to that. No money had been spent to try to figure out why there is more suicide in the West than the East. And now, there are studies going on. We need to make sure that they can continue and it is going to take a little bit of taxpayers money, but it is important. Because you see, more than 30,000 people kill themselves every year. Now, those are the people that are reported suicides. There are a lot of suicides that are car wrecks, hunting accidents, and boating accidents who really aren't listed as suicides, but they are.

As a result of these calls to action, we have suicide research centers, suicide hot lines, and the National Suicide Prevention Resource Center. This center is designed to provide States and communities with evidence-based strategies for suicide prevention. Importantly, the center collaborates with many organizations like the One Sky Center, represented today, and he will testify here, Dr.

Walker, to promote widespread implementation of a national strategy.

Here in the Senate, one of our members of our Senate family, Senator Gordon Smith, lost his 21 year old son to suicide. What a sad story. Garret Lee Smith was his name. And we all who served with Gordon heard about the love he and his wife have and had for their boy, who as a college student killed himself. The Garret Lee Smith Memorial Act became the first law to address youth suicide, so we are making progress.

Many of us here today, including you, Mr. Chairman, Senators Akaka, Johnson and Murkowski, sponsored this legislation because of its potential to help communities and families save lives. During the last session of Congress, we made some steps forward. After many, many years of talking about it, we finally stuck into one of the must-pass bills, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Act. We passed that legislation, and it was important that we did it.

We have done some other good things. Under your leadership, Mr. Chairman, the Senate passed the Indian Health Care Improvements Act last year. It is so important we took care of that, but we still were unable to get it done, for a lot of reasons. I hope we try it again. It would have created an Indian Youth Health Program for suicide prevention, intervention and treatment efforts. I repeat, it is too bad it didn't pass.

So I look forward to working with you and your colleagues to pass this legislation now, this year. If not this year, next year.

We have made some progress and that is important we talk about that, since the first hearing we had back in 1996. In fact, we have really come a long way. It is amazing what a few Congressional hearings can do to bring attention to such an important issue. We need to do more. We need to focus on populations that are particularly at risk, American Indians.

We have 26 separate tribal communities in Nevada. I have worked hard to try to understand Indian Country. Mr. Chairman, you know that the suicide rate for Native Americans, who are between ages 15 and 34, as you have already indicated, is more than two times higher than the national average. Among this age group of Native Americans, 15- to 34-year-olds, it is the second leading cause of death. That is really staggering.

In fact, the rate of suicide among youth on Indian reservations is three times greater than any other youth population. It has to be, for lack of a better description, a crisis.

The one thing that I have heard a number of you talk about, Mr. Chairman, you and Dr. Barrasso, is multiple suicides in a family. That is a study. This is not rare. It happens all the time. We have had instances of where a grandfather, a father and a son have committed suicide, in the same family. Nevada has one of the Nation's highest rates of suicide. In fact, I think we probably are the highest. The data suggests that our Native Americans in Nevada are even more likely than non-Native Americans to consider an attempt and to die from suicide, as we have already established. Outreach and awareness efforts on a number of Nevada's more remote reservations certainly make this case.

That is why I support efforts of Federal agencies, public-private partnerships, tribes and others who develop and provide suicide prevention treatment programs are vitally important. The Indian Health Service has partnered with HHS and tribes to develop and implement a suicide prevention initiative. It is behind schedule.

In recent years, SAMHSA's direct funding grants in partnership opportunities have generated research and supported programs in the field. A few Nevada tribes have received grant funds to promote prevention and provide treatment within their communities.

Then there are programs in places like Boys and Girls Clubs, tribal community buildings, native language nests and language schools that build community, provide after-school programming, and strengthen the social fabric.

Mr. Chairman, it doesn't take much. We learned in some of the hearings we held many years ago that mail carriers, people who deliver mail, can be trained, especially with certain populations like senior citizens, to see how patterns change, they don't pick up their mail, et cetera. In the State of Washington, they have had a number of programs like this which have been very successful in preventing people from killing themselves.

We have one Boys and Girls Club in Nevada, on the Walker River Paiute Reservation. We also have one youth treatment center on the Pyramid Lake Paiute Reservation. I suggest we need more to both successfully address the needs of young people and tribes.

So Mr. Chairman, members of this Committee, I so appreciate your commitment and attention to this epidemic. Holding this hearing is so vitally important, and your dedication to improving and saving the lives of Native Americans, particularly our kids. And that is what they are. We have to understand why it is happening and what we can do to slow it down and ultimately prevent it.

Thank you, Mr. Chairman.

[The prepared statement of Senator Reid follows:]

PREPARED STATEMENT OF HON. HARRY REID, U.S. SENATOR FROM NEVADA

Chairman Dorgan and Vice Chairman Barrasso, it is a pleasure to be with you today and to have the opportunity to testify before this Committee. I appreciate this Committee's interest in the issue and commitment to prevention efforts.

This is a very personal matter for me.

Thirteen years ago, I attended a Special Committee on Aging Committee hearing focused on mental illness among the elderly. At that hearing, Mike Wallace, the anchor for "60 Minutes," came forward to testify about his depression.

I was so impressed by his courage – his ability to speak publicly about a problem he had and the treatment he received. I commended him for speaking about a condition that many people associate with weakness – a stigma which still persists today. It was during this hearing that I learned unmanaged depression can result in suicide. And for the first time, I found the courage within myself, to share with my colleagues in the Senate, that my father had killed himself at age 60.

At a follow-up hearing devoted entirely to the issue of senior suicide, I spoke again about my dad's suicide. By that time, I also realized that suicide was a national problem – and particularly bad in Nevada. My father was not alone – and neither was I.

Following these hearings, I was contacted by a couple from Georgia, Elsie and Jerry Weyrauch, who had lost their adult daughter to suicide and founded the Suicide Prevention Advocacy Network to raise awareness about the issue.

With their encouragement, I proposed Senate Resolution 84 (105th Congress, 1997), which declared suicide to be a national problem, and sought to make suicide prevention a national priority. The resolution passed unanimously and was followed by a similar resolution in the House.

After former Surgeon General David Satcher was confirmed, I invited him to approach suicide as a national public health issue, and he did. In 1998, he convened a conference in Reno. The Reno Conference brought together experts from all over the country to address the problem of suicide. By the time they were finished, they had come up with a national strategy for suicide prevention.

This gave the issue real momentum. In 2001, The U.S Department of Health and Human Services published its National Strategy for Suicide Prevention, which provides a blueprint for suicide prevention in the United States. In 2002, the Institute of Medicine published its report; "Reducing Suicide: A National Imperative."

As a result of these calls to action, we have suicide research centers, suicide hotlines, and the National Suicide Prevention Resource Center. This Center is designed to provide states and communities with evidence-based strategies for suicide prevention. Importantly, the Center collaborates with many organizations, like the One Sky Center represented here today by Dr. Dale Walker, to promote widespread implementation of the National Strategy.

In 2004, under the leadership of former Senator Gordon Smith who lost his 21 year-old son to suicide, the *Garret Lee Smith Memorial Act* become the first law to address youth suicide prevention. (Pub.L. No. 108-355.) Many of us here today, including you, Mr. Chairman, and Senators Akaka, Johnson and Murkowski, sponsored this legislation because of its potential to help communities and families save lives.

During the last session of Congress, we made some significant steps forward as well. We passed the *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act.* (Pub. L. No. 110-343, § 512.) We passed legislation that would lower the Medicare coinsurance for outpatient mental health. (*Id.*)

And, under your leadership, Mr. Chairman, the Senate passed the Indian Health Care Improvement Act Reauthorization Amendments. (S. 1200, 110th Cong. (2008).) Our bill would have authorized Indian Health Services, tribes, and tribal health providers to establish a behavioral health prevention and treatment plan and create an Indian youth telemental health program in suicide prevention, intervention and treatment efforts. (*Id.* § 701, 708.) I look forward to working with you and our colleagues to pass this legislation in the 111th Congress.

We have made tremendous progress since that first congressional hearing in 1996 when no one wanted to talk about suicide. We have come a long way. I am amazed at what a few congressional hearings can do to bring needed attention to such an important issue.

But we still need to do more, and we need to focus on populations that are particularly at risk, especially Native Americans and Native American youth.

Mr. Chairman, you know that the suicide rate for Native Americans between 15-34 years old is more than 2 times higher than the national average and is the second leading cause of death for this age group. (Center for Disease Control and Prevention, Web-based Injury Prevention and Control Statistics (2005); *see* www.cdc.gov/ncipc/wisqars/default.htm .) The fact that the rate of suicide among youth on Indian reservations is greater than any other youth population is a real crisis.

While my home state of Nevada has one of the nation's highest rates of suicide among young adults, the data suggests that American Indians and Alaska Natives living in Nevada are even more likely than non-native Nevadans to consider, attempt and die from suicide. (Suicide Prevention Resource Center, State of Nevada, Fact Sheet Online (2007); *see* http://dhhs.nv.gov/Suicide/DOCS/Suicide%20in%20Nevada%20Fact%20Sheet%20Public.pdf .) While some of Nevada's tribes have begun the difficult task of implementing strategies identified in the Indian Health Service's Suicide Prevention Plan, we must help them and our most vulnerable Native people get care and support they need.

To further this goal, I support the efforts of federal agencies, public-private partnerships, tribes and others who develop and provide suicide prevention and treatment programs. The Indian Health Service has individually and in partnership with the Substance Abuse and Mental Health Services Administration (SAMHSA) at the U.S. Department of Health and Human Services and tribes developed and implemented a Suicide Prevention Initiative. In recent years, SAMHSA's direct funding, grants and partnership opportunities has generated research and supported programs in the field.

I also support programs and places -- like Boys and Girls Clubs, tribal community buildings, native language nests and schools -- that build community, provide after-school programming, and strengthen the social fabric. These programs improve the mental health and esteem of native youth. We have one Boys and Girls Club in Nevada, on the Walker River Paiute Reservation, and we have one youth treatment center, on the Pyramid Lake Paiute Reservation. I suggest we need more of both in Nevada and throughout the country to successfully address the needs of our young people and tribes.

Mr. Chairman and members of the Committee, thank you for your commitment and attention to this epidemic and your dedication to improving and saving the lives of all Native Americans, particularly our youth.

The CHAIRMAN. Senator Reid, thank you so much for being with us.

I want to put up one chart that amplifies something that you said that is so important for all of us to understand. You talked about the States with the highest youth suicide rates. You will see on these charts, it is very interesting that almost all of them are Midwest and Western States. You indicated that no one quite knows why that is the case, but that is a really interesting chart. It is something I had not known before I saw this chart yesterday.

Does anyone have questions of Senator Reid?

I know, Senator Reid, that it is intensely personal for you to speak about these issues, and yet I think your decision previously to speak out on these issues is enormously beneficial to our Country and to others who hear your testimony. I very much appreciate your willingness to come today.

Senator REID. Byron, it has been good for my family. It has been good for the family to confront this issue and not be embarrassed. No one should be embarrassed about this. No one should feel it is their fault. There are organizations out there, lots of them now, who will help people work their way through this. Whenever I see someone where there is a suicide, I try to call them and give them organizations that can help.

The CHAIRMAN. Well, thank you so much for being here today. I think it does provide an inspiration to others, so thank you for being with us.

We have a list of witnesses today. I indicated that there will be a vote at about 10:30 a.m. We probably will break about 20 minutes to 11 a.m., that is 20 minutes from now, to go vote and come back. We will have a brief recess.

But I want to call on Ms. Dana Lee Jetty, who is a student at Minnewaukan Public School and a member of Spirit Lake Dakotah Nation, Fort Totten, North Dakota; the Honorable Robert Moore, Member of the Great Plains Tribal Chairmen's Association, and the Aberdeen Area Tribal Chairmen's Health Board; Dr. Dale Walker, Director of One Sky Center, Oregon Health and Science University in Portland, Oregon; Mr. Hayes Lewis, Director of the Center for Lifelong Education, Institute of American Indian Arts at Santa Fe, New Mexico; and Dr. Teresa LaFromboise, Associate Professor at Stanford University School of Education.

I want to say to our colleagues, the Honorable Robert McSwain and Dr. Eric Broderick, that normally, I would call you first. I would like, with your permission, to call you after this panel so that you have a chance and an opportunity to listen to this panel, and then respond. So I appreciate your indulgence and thank you so much for that.

Let me begin with Dana Lee Jetty. Dana Lee Jetty is here with her family. The circumstances of our inviting her here are very tragic circumstances. I know how difficult these things are. It is good of you to come. Dana Lee's sister took her life. Her sister's name was Jami Rose Jetty. It was just last November. She is a high-schooler in Minnewaukan, North Dakota, which is on the edge of the Spirit Lake Nation Reservation. She has agreed to come with her parents and visit with us today. I am going to begin with you, Dana Lee. You may proceed.

STATEMENT OF DANA LEE JETTY, STUDENT, MINNEWAUKAN PUBLIC SCHOOL; MEMBER OF SPIRIT LAKE DAKOTAH NATION

Ms. JETTY. My name is Dana Jetty. I am 16 years old and I am an enrolled member of the Spirit Lake Tribe of North Dakota. Before I begin, I would like to thank the Committee for giving me the opportunity to talk to you about my family and, more importantly, about my sister Jami.

Jami was 14 years old. She had a lot of friends and was mature for her age. Jami was open-minded and always asking questions about anything and everything. She was very caring, sweet, compassionate and never judged anyone. She saw the world in black and white, and found pleasure in simple things like listening to old stories from long ago. Jami was like any other teenage girl from a middle-class home surrounded by a family who loved her.

November 3, 2008 started as a day like any other, but it ended as a day that I will never forget. November 3, 2008 is the day that my baby sister, Jami Rose Jetty, ended her own life. My sister and I were home that day and Jami woke me up about 9:30 in the morning to tell me that she felt sick and dizzy. I knew my sister had been having problems with depression, and I asked her if she had taken anything. She told me she had, so I immediately called

my mom at her office. My mom came to the house right away, but Jami refused to tell her what she had taken and refused to go to the clinic.

My mom told me to keep an eye on Jami while she went to make some calls to see what kind of help she could get for my sister. Of course, my sister was angry with me for calling my mom, but I talked to her for a while anyway. After Jami talked for a while, she asked me to leave her alone. I hesitated, but decided to give her some space.

After I left her alone, I watched TV and made some food. I decided to clean up and called for Jami to come help me, but she did not respond. I walked towards the back of the house and saw that the bathroom door was closed, but the light was on. I opened it, but she was not in there. I looked towards Jami's bedroom and her door was also closed. I opened it, and I was instantly flooded with feelings of fear and shock. It was like a horrible dream that I cannot wake up from.

I saw my sister with a belt fastened to the bunk bed and wrapped around her neck. Jami was sitting lifelessly, her body leaning against the wall. I ran to get my boyfriend and I tried to get the belt off her neck, but it was too tight. My boyfriend got a knife and cut her down. All I could do was yell, why, as I rocked her lifeless body in my arms.

The next thing I recall is my mom and dad running into the house. I watched as my mom frantically called the police and my dad desperately tried to perform CPR. Within minutes, the police and paramedics arrived. Even though the paramedics did get a slight pulse, my sister, Jami Rose Jetty, was not alive when she arrived at Mercy Hospital in Devils Lake, North Dakota.

On November 3, 2008, I lost my sister and my best friend. On November 3, 2008, my life and my family changed forever. Suicide has left me feeling lost, lonely and angry. I don't understand why my sister felt that she had to do this, and I don't know why she didn't ask me for help or tell me what she was thinking. Knowing my sister, she would not have wanted to burden others with her problems, but I wish she would have told me.

I, along with my family, have turned to our spirituality and our faith to guide us through this dark time. We have prayed. We have attended sweat ceremonies, and we have talked to whoever will listen to share our experience. In the aftermath of my sister's suicide and in the ceremonies we attended, we have come away with a message from Jami that we are now passing along to others: Tell the ones that are trying to end their lives this way, it is not the way to go.

And so my sister's message has become a mission for my family. We have attended meetings in our community to tell anyone that is considering suicide that it is not the way to go, and that there are people who can help. In talking to our community, we have found that suicide is a much more common problem than we ever realized. People in our community have opened up to us and have shared their feelings of suicide and have expressed the shame that they feel for having those thoughts. I never imagined that so many people had these thoughts and kept them inside out of a sense of shame and hopelessness.

While I am surprised at how many people feel suicidal, I am not shocked at the hopelessness they feel. I know that my mom had concerns about my sister before her suicide. My mom did all the right things. She took her to the doctor. She talked to counselors and she was even evaluated by mental health professionals from Indian Health Services. The mental health providers dismissed my mom's concerns and diagnosed my sister as being a typical teenager. I know my mom is angry that these professional people did not provide the help she needed, and her strength and ability to forgive is amazing.

Now, our mission has led us to Washington, D.C. Today, I, along with my family, ask you to support our efforts to prevent suicide by funding and developing quality programs and health services in our tribal communities. It is not enough to put a counselor in a community. We need trained professionals who really know how to help our communities. We can stop others from committing suicide if we talk openly in our communities and if we provide supportive places for people to go when they need help for themselves or for their family members.

We need to make sure that our communities and our people know how to reach out for help if they need it, and we need to make sure that help is there when they ask. We need to share Jami's message: Tell the ones that are ending their lives this way that it is not the way to go.

And so today, I am here on behalf of my sister Jami Rose Jetty to ask for your help. I ask that you support suicide prevention programs in our tribal communities, and I ask that when you have your discussions on the issue of suicide, you remember my sister. She was 14 years old. She was a beautiful, outgoing teenager with her whole life ahead of her. She was my sister, and she is what suicide looks like in Indian Country.

Thank you for giving me the opportunity to share Jami's message with you today. Thank you.

[The prepared statement of Ms. Jetty follows:]

PREPARED STATEMENT OF DANA LEE JETTY, STUDENT, MINNEWAUKAN PUBLIC SCHOOL; MEMBER OF SPIRIT LAKE DAKOTAH NATION

My name is Dana Jetty, I am 16 years old and I am an enrolled member of the Spirit Lake Tribe in North Dakota. Before I begin I would like to thank the Committee for giving me the opportunity to talk to you about my family and more importantly about my sister Jami.

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anyway. After Jami talked for a little while, she asked me to leave her alone. I hesitated but decided to give her some space.

I left her alone and watched TV and made some food. I decided to clean up and called for Jami to come and help me, but there was no response. I walked towards the back of the house and saw that the bathroom door was closed but the light was on. I opened it but she was not in there. I looked towards Jami's bedroom and her door was also closed. I opened it and was instantly flooded with feelings of fear and shock. It was like a horrible dream that I could not wake up from. I saw my sister with a belt fastened to the bunk bed and wrapped around her neck. Jami was sitting lifelessly, her body leaning against the wall. I ran to get my boyfriend and I tried to get the belt off her neck but it was too tight. My boyfriend got a knife and cut her down. All I could do is yell "Why?" as I rocked her lifeless body in my arms. The next thing I recall is my mom and dad running into the house. I watched as my mom frantically called the police and my dad desperately tried to perform CPR. Within minutes the police and paramedics arrived. Even though the paramedics did get a slight pulse, Jami Rose Jetty, my baby sister, was not alive when she arrived at Mercy Hospital in Devils Lake, ND.

On November 3, 2008 I lost my sister and my best friend. On November 3, 2008 my life and my family changed forever. Suicide has left me feeling lost, lonely and angry. I don't understand why my sister felt that she had to do this and I don't know why she didn't ask me for help or tell me what she was thinking. Knowing my sister she would not have wanted to burden others with her problems, but I wish she would have told me.

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And so my sisters' message has become a mission for my family. We have attended meetings in our community to tell anyone that is considering suicide, that this is not the way to go and that there are people who can help. In talking to our community we have found that suicide is a much more common problem than we ever realized. People in our community have opened up to us and have shared their feelings of suicide and have expressed the shame that they feel for having those thoughts. I never imagined that so many people had these thoughts and kept them inside out of a sense of shame and hopelessness. While I am surprised at how many people feel suicidal, I am not shocked at the hopelessness they feel. I know that my mom had concerns about my sister before her suicide. My mom did all the right things. She took her to the doctor, she talked to counselors, and she even had her evaluated by mental health professionals from Indian Health Services. Those mental health providers dismissed my moms concerns and diagnosed my sister as being a "typical teenager". I know my mom is angry that these professional people did not provide the help when she needed it and her strength and ability to forgive is amazing.

Now our mission has led us to Washington, D.C. and today I, along with my family, ask you to support our efforts to prevent suicide by funding and developing quality programs and health services in our Tribal communities. It is not enough to put a counselor in a community. We need trained professionals who really know how to help our communities. We can stop others from committing suicide if we talk openly in our communities and if we provide safe and supportive places for people to go when they need help for themselves or their family members. We need to make sure that our communities and our people know how to reach out for help if they need it and we need to make sure that the help is there when they ask. We need to share Jami's message: ". . . tell the ones trying to end their lives this way, that it is not the way to go. . . ".

And so today, I am here on behalf of my sister, Jami Rose Jetty to ask for your help. I ask that you support suicide prevention programs in our tribal communities and I ask that when you have your discussions on the issue of suicide you remember my sister. She was 14 years old. She was a beautiful, outgoing teenager with her whole life ahead of her. She was my sister and she is what suicide looks like in Indian Country.

Thank you for giving me the opportunity to share Jami's message with you today.

The CHAIRMAN. Well, Dana, thank you very much. You have given all of us today an opportunity to remember your sister. My guess is that your little sister would be enormously proud of you.

Ms. JETTY. Yes.

The CHAIRMAN. The tragedy that has visited your family and the loss of your sister is intensely personal and intensely emotional to your family. And yet, for all of us to try to find lessons here that might help others who experience this tragedy is so important.

I mentioned in the opening statement the death of Avis Little Wind on the same Indian reservation.

Ms. JETTY. Yes.

The CHAIRMAN. She, too, hung herself at age 14. I spent time going there, talking to everybody I could talk to to understand what happened there.

Ms. JETTY. Yes.

The CHAIRMAN. There are not obvious or easy answers. Often, it is very complicated. But the one thing that was clear to me and has always been clear to me, and is true on almost every Indian reservation, there is not readily accessible treatment by qualified professionals that are available. It is something we have to fix. I mean, this is a great tragedy.

So we all appreciate very much your being willing to come and do something that I know is very, very difficult for you and your family to do, and that is speak publicly about it. You heard our colleague, Senator Reid, describe the inclination not to talk about these things.

But I think your willingness to come to Washington, D.C. and to speak publicly about these things will help others. So we appreciate that.

Ms. JETTY. Yes.

The CHAIRMAN. What I am going to do, with the permission of my colleagues, is hear from the other witnesses, and then we all have a chance to ask Dana questions and other witnesses questions, if that is permissible. We likely will have to be interrupted by this recess for a vote.

Let us start with the Honorable Robert Moore, who is a member of the Great Plains Tribal Chairmen's Association and, a Council Member of the Rosebud Sioux Tribe

Mr. Moore?

STATEMENT OF HON. ROBERT MOORE, MEMBER, GREAT PLAINS TRIBAL CHAIRMEN'S ASSOCIATION AND ABERDEEN AREA TRIBAL CHAIRMEN'S HEALTH BOARD; COUNCIL MEMBER, ROSEBUD SIOUX TRIBE

Mr. MOORE. Thank you, Mr. Chairman. Thank you again. It is a pleasure to see you as well again.

I am very honored and humbled to be here to represent the many tribes of the Great Plains, with which you are very familiar. You mentioned several of your own experiences out there in hearings and understanding, particularly at Standing Rock and others, like the story of Jami. There are hundreds of those stories in our area alone.

In the Aberdeen area, as a matter of fact, when you look at some of the statistics, the national death rate from suicide is approximately 10 per 100,000, 17 per 100,000 in the IHS population and the service area, and in the Aberdeen area alone, it is over 22 per 100,000.

At Rosebud, we have been sort of identified as the epicenter of suicide in Indian Country. Recently and just yesterday, Indian Health Services service unit at Rosebud released an alarming statistic. In our tribe alone, the suicide rate is 200 per 100,000 for males ages 15 to 24, which right now puts us as having the highest suicide rate in the world, in that little pink rectangle that Rand McNally calls the Rosebud Sioux Indian Reservation in your atlas.

It is very alarming. There is not a single family member or tribal citizen at Rosebud that has not been directly impacted by the overwhelming number of suicides in our area. As a result of this, and as a result of the growing concern of elected tribal leadership and the entire community, we responded in a way that really organized and efficiently and effectively brought together tribal agencies to respond from all levels, including areas of law enforcement, alcohol and substance abuse, our tribal university and others.

As you know, in Indian Country it is very important for us to have a very holistic approach to not just suicide, but to the overall wellness of all of our community, which includes those areas like law enforcement and education. And then we can be able to more directly address suicide.

I have several recommendations that are, I think, important for us to talk about. One is we need improved collaboration, not only with what we currently have experienced, and I have to extend a great amount of appreciation to Mr. McSwain, Mr. Broderick and others who have really helped us and joined together as an overall HHS Department-wide response to our situation specifically at Rosebud. But we need improved collaboration, cooperation and data-sharing between IHS and tribes, and elevating suicide to a very reportable medical system of reporting so that the information is out there for tribes and IHS to be more response than they are and have been so far.

IHS has to change its health care paradigm. Right now, IHS is really responsible for response to medical situations and to Medicaid. But in their own mission statement, they have identified health promotion and disease prevention as one of their leading missions. So we want to work with them to be able to shift that whole paradigm so that we are able to really provide a well and healthy community.

Another area that we need to talk about is early childhood trauma. I have been asked to represent that point in that a lot of the suicides that have occurred, at least at Rosebud and in our area, can be directly identified to an incident that occurred in early childhood, but we don't have the resources and mechanisms in place to address that when it actually happens.

However, in some of our programs, we have done very well at addressing the mental health needs of children. Our diabetes prevention program is one. We have had great success in addressing the mental health of our children who are showing early onset of Type 2 diabetes. In doing that, it has helped address and alleviate some of those mental health issues in those homes, but that is only just a small pocket in our community.

We also need the resources to really reach out and develop home-based, community-based response to suicide and to the behavioral and mental health issues in our tribal communities, where we have

actual citizens engaged in response, actual citizens engaged in promoting and addressing the self-esteem of our children. One of the leading causes of suicide is lack of self-esteem.

So one of the things that we are doing in Rosebud is we have established the Wiconi Wakan Health and Healing Center. It means life is sacred. Our faith-based community and our traditional spiritual leaders have really joined together to invoke the spiritual life of our tribal citizens at Rosebud, particularly, as they have around the Country. It is a very spiritual issue for tribal citizens.

Then finally, as we look at one of the issues that was mentioned in the earlier testimony from Jami's sister, is having the appropriate people in place at IHS and other Federal agencies or other systems of care in Indian Country. That means cultural competency. A lot of folks would say, oh, Jami's situation is that of just a typical teen, without fully understanding some of the cultural life that we have and having the competency to address that part of our lives in Indian Country.

You have my written testimony. We will be glad to continue to work with you and the entire Committee and your staff as we join together in Indian Country to address this issue one on one. In fact, this Sunday we have our second Suicide Task Force meeting, which is conducted with the National Congress of American Indians. We had our first Suicide Task Force meeting this last fall in Phoenix. We are joining forces on a national level to address the situation and to provide resources and opportunities for tribes to respond.

Thank you.

[The prepared statement of Mr. Moore follows:]

PREPARED STATEMENT OF HON. ROBERT MOORE, MEMBER, GREAT PLAINS TRIBAL CHAIRMEN'S ASSOCIATION AND ABERDEEN AREA TRIBAL CHAIRMEN'S HEALTH BOARD; COUNCIL MEMBER, ROSEBUD SIOUX TRIBE

Introduction

Mr. Chairman and other Members of the Committee, thank you for your hard work to ensure that the appropriate authority and funding for health care services is available to meet the needs of the 17 Tribal Nations of the Great Plains, and thank you for the opportunity to provide this testimony on behalf of the Rosebud Sioux Tribe and all the Tribal Nations of the Great Plains Tribal Chairman's Association. I am Robert Moore, Elected Councilman of the Antelope Community, Rosebud Sioux Tribe of South Dakota. I am here today representing the Great Plains Tribal Chairman's Association (GPTCA), and the Aberdeen Area Tribal Chairmen's Health Board (AATCHB) -an Association of seventeen Sovereign Indian Tribes in the four-state region of SD, ND, NE and IA. The Great Plains Tribal Chairman's Association is founded on the principles of unity and cooperation to promote the common interests of the Sovereign Tribes and Nations of the Great Plains and their citizens.

Great Plains Region

The GPTCA stands on the Fort Laramie Treaty of 1868 (15 Stats. 635) Articles IV, V and IX that guarantees that the United States will provide health care services at the local level to our people and will reimburse the Tribes for any services lost. It was clearly understood by the Indian signers of that Treaty that necessary assistance would be provided to the signatory Tribes by the Indian agent and a local physician (or Superintendent or the Director of Indian Health Service in the modern era) and that sufficient resources would be made available to the physician to allow him to discharge the duties assigned to him. Indian health care fulfills a fundamental Treaty obligation and our Tribal people take this obligation very seriously. It is important to note that as Tribal members, we are the only population in the United States that is born with a legal right to health care. This right is based on

treaties in which the Tribal Nations exchanged land and natural resources for several social services, including housing, education and health care.

The Great Plains Region, aka Aberdeen Area Indian Health Service, has *21 I.H.S. and Tribally managed service units.* We are the largest land based area served of all the Regions with land holdings of Reservation Trust Land of over 11 million acres. There are 17 Federally recognized Tribes with an estimated enrollment of close to 200,000 tribal citizens. *The Tribes of the Great Plains are greatly underserved by the I.H.S. and other federal agencies with the I.H.S. Budget decreasing in FY 2008 over the FY 2007 amount. This is in spite of increased population size and worsening health disparities.* The GPTCA/AATCHB is committed to strengthening direct health care systems and all Federal Programs in a comprehensive delivery to improve the lives of our enrolled members and in particular our Youth of the Seventh Generation. In the past few years, unfortunately, our Tribes have experienced an increase of Suicides.

Health Data and Overview

As documented in many reports, the Tribes in the Great Plains region suffer from among the worst health disparities in the Nation, including several-fold greater rates of death from numerous causes, including diabetes, alcoholism, infant mortality and suicide. For example, the national infant mortality rate is about 6.9 per 1,000 live births, and it is over 14 per 1,000 live births in the Aberdeen Area of the Indian Health Service—more than double the national rate. The life expectancy for our Area is 66.8 years—more than 10 years less than the national life expectancy, and the lowest in the Indian Health Service population. Leading causes of death in our Area include heart disease, cancer, unintentional injuries, diabetes and liver disease. While the numbers are heart-breaking to us, as Tribal leaders, these causes of death are preventable in most cases. They, therefore, represent an opportunity to intervene and to improve the health of our people. Additional challenges we face, and which add to our health disparities, include high rates of poverty, lower levels of educational attainment, and high rates of unemployment. All of these social factors are embedded within a health care system that is severely underfunded. As you have heard before, per capita expenditures for health care under the Indian Health Service is significantly lower than other federally funded systems, including the health care provided to Federal prisoners.

Specifics on Suicide

Unfortunately, youth suicide has had a severe and devastating impact on the Great Plains tribes. The national death rate from suicide is approximately 10 per 100,000 population, and it is 17 per 100,000 in the IHS population. In the Aberdeen Area IHS, the suicide rate is *over 22* per 100,000 population-more than double the national rate. Adding to these disheartening numbers is the fact that suicide is more common among American Indian and Alaska Native *youth,* whereas suicide rates tend to increase with advancing age among the general population. According to the Centers for Disease Control and Prevention (CDC), from 1999–2005, among youth age 10–19 years nationally, the suicide death rate was *4.5* per 100,000 population.

In South Dakota, where I am from, among American Indians during the same timeframe, the suicide rate was *over 38* per 100,000 population—more than eight times the national rate. The result is that not only do we have a higher percentage of people committing suicide, we have a higher percentage of *young* people killing themselves—resulting in an even greater number of years of potential life lost in our populations. In addition, the Great Plains region suffers from extreme disparities in health, educational opportunities, and poverty, and suicide among our young people is limiting the potential of future generations to overcome these challenges.

Our young people live in great despair—witnessing the extreme emotional and social impact of high rates of infant deaths, living with poverty and often within abusive households, and watching other young people taking their own lives. The result is that we tend to see clusters of youth suicides in many of our communities, including my home in Rosebud, SD.

Over the past several years, the lack of resources, funding and staffing has taken its toll on our Tribal communities. It takes a community to raise a healthy child, and when you have school systems that needs strengthening due to lack of funds, a law enforcement department that is not operating at full capacity, a health care system that is inadequate, lacking proper funding and adequate staffing (such as no mental health care) combined with poverty, substance abuse, lack of jobs and quality of life, our People suffer. And, our Children suffer most of all.

The following are words directly from a teenager whose 14 year old sister committed suicide last November in North Dakota:

Jami was in a sitting position against the wall on her bed with a belt around her neck. The belt was tied to the bars of the top of her bunk bed which was leaning against the wall. I ran into the living room and told my boyfriend what Jami had done, then I ran back into Jami's room and he followed. I tried to take the belt off of her neck but it was too tight. Then my boyfriend cut her down. After that, I called my Mom and Dad. I sat there holding her till they came. I was crying uncontrollably talking to her asking her, "Why?"

I couldn't comprehend what had just happened. Then I heard my Mom and Dad come running in. My Dad started to do CPR on her, and my Mom was on the phone calling the Police Department to get the ambulance here. Then not even five minutes later they were here. The paramedic worked on her with no response, they did get a slight pulse at one time, and then they rushed her to the hospital.

She was already gone by the time they got there. The doctor at the hospital said if she would've survived she would have been brain dead.

The experience of losing my sister, best friend, someone I confided in, is very painful and hard to accept. I feel lost, lonesome, alone, and sometimes angry because I don't know why she did this while I was just in the other room. We always told each other "everything". She didn't tell me how she felt. I know she thought that I had enough of my own problems and didn't want to burden me with hers, but she still could have told me.

It's been a few months now and I still feel lost, lonesome, and alone, but what I have learned from this is; don't keep things to yourself, talk to someone because there is always someone there for you who is willing to listen and help you.

Over the last several years in the Rosebud Sioux Tribe alone, we have witnessed dozens of suicides and *hundreds* of documented suicide attempts. The situation became so bad that in 2007 our Tribal President declared a State of Emergency in order to draw attention and resources to the problem. This year, 2009, there has already been 1 suicide and more than a dozen attempts in less than 2 months.

Rosebud Model

Chairman and Members of the Senate Indian Affairs Committee, to lose one of our Youth hurts our entire Community and Tribe. Our Tribal Leaders and community health advocates have worked tirelessly to find out what the roots of the problem are, and to see how we can improve our situations and prevent more suicides. Several projects have begun to address the problem of youth suicide. For example, on Rosebud we have started or expanded several programs, including:

- Wiconi Wakan Health and Healing Program
- "Safe Schools Project" in collaboration with Todd County Schools
- Suicide Task Force
- White Buffalo Calf Pipe Women's Program
- Alcohol and Drug Treatment Program
- RST Tribal Health Program (including Tribal Education and CHR Program), with the support of IHS's "point man" for Suicide Prevention/Intervention, Austin Keith (just arrived last week) will be able to physically follow up on every suicide completion and attempt, and begin tracking every suicide attempt with a Rapid Response Team approach.
- Suicide Prevention Grant
- Suicide Summits and Meetings with community members and leadership

The response and efforts conducted in the Rosebud Sioux Tribe have been remarkable, and we are hoping to have an impact on reducing suicide permanently in our community. Unfortunately, these efforts were not started in time to save many of our young people, and in the sixteen other tribal nations in our region, not enough is being done to focus on suicide prevention. In addition, we need a well-coordinated data, surveillance and response plan to meet the needs of all our communities. Regrettably, most of our communities do not have access to Area-wide and community-specific data that is managed by the IHS. In our region, most medical services and datasets are managed by the IHS at the federal level, and most of our public health programs are managed by the tribes. We *need* improved collaboration, cooperation and data sharing between the IHS and the tribes. According to Dr. Donald Warne, Executive Director of AATCHB, the Health Board has no reports or data sets with Area level data specific to suicide. As we attempt to improve our system of epidemiology related to suicide and mental health, this is precisely the problem. Although

the IHS collects and maintains administrative and clinical data on patients seen in IHS clinics, these data are not readily accessible nor useful for the traditional public health functions of population monitoring, investigation, program planning, and evaluating the effectiveness, accessibility and quality of health services.

For suicide, we need to develop a public health care infrastructure that is capable of supporting a "Rapid Response" approach and follow up to suicide events attempts/gestures and completions in all of our communities. This implies creating a data collection and monitoring system that allows ready access to actionable data at a moment's notice. Such a system cannot rely on passive surveillance alone (i.e., voluntary), which is currently the case. Therefore, I would first recommend that suicidal behavior be elevated to the status of a reportable event throughout the Aberdeen Area. That means mandated reporting of all suicidal behavior in a timely manner by all providers (including first responders). Secondly, surveillance should apply to all levels of jurisdictional access (community, Tribal, Area) on a need-to-know basis. Suicidal contagion gives no credence to reservation boundaries. An electronic, integrated, surveillance system could accomplish these objectives. Finally, an active suicide surveillance system could serve as the starting point for the development of a more extensible infrastructure that supports focused, targeted interventions and coordination of care through automated analysis of factors relevant to crisis management and suicide prevention/intervention (i.e. who intervenes, when they intervene, with whom, and others).

IHS must change its health care paradigm to one of "Disease Prevention and Health Promotion" rather than just treating medical and behavioral problems after they begin. Our People need wellness education programs, exercise and healthy foods that are closely integrated with our traditional belief systems. Our Children need improved self-esteem and a stronger sense of hope for the future if they are to live in a healthy way. To achieve these goals, we need more resources to develop healthy communities. The health of the community often determines the health of the families and the health of the children. Suicide is preventable, but we need resources in order to continue our community healing efforts.

Sufficient Resources

What would it take to give the Indian Health Service (IHS) sufficient resources to address our health care needs? The current appropriation for IHS clinical services is about $3.4 billion. Our estimated funding percentage based on documented level of need is approximately 50–60 percent of that need. In order to bring IHS up to a more appropriate level of funding, an additional $2 billion for clinical service would be needed nationally making our annual Federal appropriation closer to $5.4 billion. This would be a major increase, but a small one relative to the $700 billion budget for the Department of Health and Human Services (DHHS). A significant portion of these additional resources need to be directed toward behavioral health, suicide prevention and holistic care that meets the needs of our young people and our future generations.

Summary

In closing, we do not want to lose any more of our Youth. We seek to take on directly the terrible disparities that make our population's health status comparable to a third world country. As the nation takes on the ideas of health care reform, as President Obama noted in his address before Congress on Tuesday evening, February 24, 2009, please ensure that American Indian and Alaska Native communities and leaders are included its development. Also, please ensure that national efforts at health promotion take into account the unique needs and health disparities of our nation's first inhabitants. Thank you, again, for this opportunity and your attention to these vital matters.

The CHAIRMAN. Mr. Moore, thank you very much.

I did not mention in the opening statement, because I truncated my remarks, that a lot of us have personal acquaintance with these issues. Mine was pretty profound, and had a huge impact on my career. I walked in the office of a friend and a boss in the State Capitol who had just been elected to a State-wide elected office. He had been a 38 year old Harvard-trained lawyer from a town of 80 people in North Dakota. That is some accomplishment, to leave a town of 80 people and get a law degree from Harvard and be elected to a State-wide office. I walked in his office one day and found him dead. He had committed suicide.

So I have, and all of us do, I suppose, in various ways very personal acquaintances with suicide. In this case, it was a very close friend that I found one morning in his office. I think it is a tragedy always, but magnified especially by young people who decide that things are hopeless and helpless and they must end their life at a very young age.

What I would like to do is recess. The vote started 10 minutes ago. We can vote and come back, and I would expect we will be back in 15 minutes and continue the hearing.

Thank you very much. We are in recess.

[Recess.]

The CHAIRMAN. The hearing will come to order.

Next, we are to hear from Dr. Dale Walker, M.D., Director of One Sky Center, the Oregon Health and Science University in Portland, Oregon.

Dr. Walker, thank you for being with us.

We apologize to all of you for the delay, but we must go vote when the rolls are called here in the Senate. We appreciate your indulgence.

STATEMENT OF R. DALE WALKER, M.D., DIRECTOR, ONE SKY CENTER, OREGON HEALTH AND SCIENCE UNIVERSITY

Dr. WALKER. Senator, I am happy to hear that business goes on. That is always good to see.

Indeed, it is an honor to be here with all of you and to hear the story, Dana, that you have shared with us. I think that makes us think especially about this problem, and I thank you for sharing.

I want to first of all, identify the One Sky Center as a national resource center for American Indian alcohol, drug, and mental health. We provide an outreach to well over 100 communities, tribes, Indian communities, urban programs, across the Country. That gives us incredible information and personal stories about what is happening in our communities.

It is true that we have all personally had these experiences happen to our families and people in our community. But within an American Indian community, the loss of a life or the loss of a cluster of lives is a unique phenomena. In my view, it is defined very easily as a disaster for that community. If you have a small community of 3,000 in a reservation, if you have 8,000, and you have 17 lives that are lost, teenagers, early 20s, and how that impacts the community in the short term and the long term, carries with it a major burden of illness. That burden of illness is complicated by the multiple problems.

Suicide is a chronic problem, a chronic illness, if you will, but it is additive. You know, all of the other things that we have heard about, the addictions problems, the housing problems, severe domestic violence, community violence, all of these things together create community moods and community problems. The feeling of hopelessness and helplessness that you mentioned within an individual is felt within the community.

I still remember when I did my first evaluation at Standing Rock. One of the Elders said, we are tired of suffering. We can suffer and feel no more. We are numb to the losses. That is when I think of the phrase, disaster. That is when I think that we need

to be really attentive to the problems when they happen at Rosebud and Wind River and Standing Rock and Alakanuk, and places that we all know well and we know the difficulties there.

The One Sky Center has worked in those areas providing technical assistance, consultation, and probably as important as anything we do, is gather information to put into tool kits and information packages that are unique and defined for the community. That is information they need to help recover from the problems that they have.

Community mobilization is something that we will hear from SAMHSA and the Indian Health Service. I can only tell you that I think that is one of the critical elements of recovery within a community is for the community to open up, discuss and understand the difficulties, and begin to make decisions based upon who they are, the people they are, the culture they have. Those elements are critical.

Now, the other piece that I don't want to understate is the need for good quality health care, medical services, mental health care and delivery within those communities. I have sat in front of this Committee and said before that not all of the Indian health need is performed and completed by the Indian Health Service.

We don't expect that, but we expect the agencies across the Federal Government to gather together and garner resources in such a way that people can deal with these health care problems. We have 13 recommendations and they kind of fit in six areas. When we went through to think about this, we thought that the policy administration area was our most critical.

We recommend that two particular items be addressed. I think that it would be useful that a standing committee or a task force be developed at the HHS level to help the collaboration, coordination and cooperation necessary across agencies to work with Indian people. Money comes at Indian communities in small silos. Each one has definitions and special purposes, but they don't work together. That actually divides the ability of the tribes to make decisions about their generalized health care because they have to address from 28 up to 37 grants for mental health care, each one with a project officer who hasn't been to their reservation.

So we have the difficulty of trying to integrate those services, helping the tribal councils manage the health care needs of their communities. I think that is an area that we really need to think about how we can integrate those services effectively.

Another issue that can only be stated this year, and that is that we need to take a serious look at where health care reform is going nationally in this Country, and hook the stars of the Indian communities to that change. We need a blue ribbon task force and we need Indian involvement in health care reform in this Country. They need to be a part of that and a part of the reform that would happen.

Now, I have gone through, and I have mentioned other pieces of information in regards to community competence, youth and family development, training and education, and clinical services, but I think if I can leave you with the point that we have a lot of work to do. We know a lot about the clinical care and services, but access

to care, as someone mentioned here, is a critical point and a critical element for us to deal with.

I hope that we can do the training and the education, the outreach and the community mobilization and make things happen. We need to continue the programs like Native Aspirations, like Project HOPE, and One Sky Center, so we can continue to do this work. We are working hard to maintain a permanent relationship with the health care field.

I will stop now. I know we have so many things to say, but I always want to tell you that the One Sky Center is a resource center for the Indian communities, but it is also for you. I would welcome, and I thank your staff for the outreach and the wonderful work that you are doing.

[The prepared statement of Dr. Walker follows:]

PREPARED STATEMENT OF R. DALE WALKER, M.D., DIRECTOR, ONE SKY CENTER, OREGON HEALTH AND SCIENCE UNIVERSITY

Introduction

Mr. Chairman, Vice-Chairman, and members of the Committee, my name is R. Dale Walker, M.D.. I am the Director of the One Sky Center, the American Indian/Alaska Native (AI/AN) National Resource Center located at Oregon Health & Science University in Portland, Oregon. I am a Cherokee psychiatrist with over 30 years experience in the fields of substance abuse and mental health. I have worked with native people, veterans, health & medical professionals, and tribal communities. I am also a member and immediate past president of the Council of Advocacy and Public Policy for the American Psychiatric Association, in addition to being a long-time member of the Association of American Indian Physicians. Finally, I am a member of the Advisory Council of the National Institute of Drug Abuse (NIDA).

I thank the Committee for inviting the One Sky Center to testify as an expert witness on suicide prevention in Indian Country and to comment on recent trends in youth suicide among American Indian and Alaska Natives.

It was my great honor to testify in front of this Committee twice in the 109th Congress on Indian health and suicide prevention. I look forward to updating my earlier reports to you on the suicide prevention efforts of One Sky Center and some allied organizations. While suicide remains a devastating problem throughout much of Indian Country, many notable culturally appropriate initiatives are also underway.

Current Suicide Prevention Initiatives in the Pacific Northwest

The One Sky Center is allied with other national, regional, and local entities working on suicide prevention in Indian Country. Following is an update on One Sky Center and some of the regional entities not appearing at this Senate Hearing.

One Sky Center

In May 2006, the One Sky Center testified on teen suicide prevention. As the first National Resource Center for American Indians and Alaska Natives dedicated to improving substance abuse and mental health services in Indian Country, the One Sky Center has provided training, technical assistance, and lent expertise on suicide prevention affecting American Indian and Alaska Native people and tribal communities.

The One Sky Center has produced various culturally relevant resources for tribal communities. (See attachment). One Sky Center products, available online via our website, include: *Motivational Interviewing Enhancement Curriculum for Tribal Youth* with training guidebooks, culturally appropriate *Service Learning Curriculum,* a first of its kind *A Guide to Suicide Prevention for American Indian/Alaska Native Communities* with a community assessment tool for American Indian and Alaska Native youth, a *Best Practices in Behavioral Health Services for American Indians and Alaska Natives* monograph, and a *Describing Culture-Based Interventions for Suicide, Violence, and Substance Abuse* monograph.

In addition, the One Sky Center has been involved in two national initiatives, the "Native Aspirations Project" (NA) of Kauffman Associates, Inc., and the "Indian Country Methamphetamine Initiative" (ICMI) of the Association of American Indian Physicians. In these efforts to reduce suicide and closely related problems, the One

Sky Center provides clinical, programmatic, and research expertise and assistance in the form of consultation, education, training, and production of guidebooks, all in a manner appropriate to the need in Indian Country.

Tribes and tribal organizations with scarce financial resources look to the One Sky Center to learn from medical and scientific disciplines and from what is working in other tribal communities. It has been One Sky's honor to be able to assist.

Many lists of "Best Practices", including suicide prevention programs, have been published. However, the form and success of best practices depends heavily on tailoring for cultural and local context. With financial assistance from Substance Abuse and Mental Health Service Administration's (SAMHSA) Center for Mental Health Services (CMHS), the One Sky Center reviewed evidence-based suicide prevention programs developed by, actually adapted to, or potentially useful in Indian Country, and produced a *Suicide Prevention Guide* to help disseminate this information throughout Indian Country. This document has passed through several phases of review and its approval by SAMHSA for dissemination is eagerly awaited by Indian Country.

Similarly, the One Sky Center assisted Indian Country experts to develop and disseminate culturally specific interventions for suicide and to train others in their application. These include Native *Helping Our People Endure* (HOPE); Project *Venture;* and a Tulalip tribal adaptation for children of the *Canoe Journey/Life Skills* program.

The One Sky Center has served as a source of expertise and advocacy in suicide prevention in Indian Country for government, public, and private entities. This activity spans awareness raising, coalition building, motivation enhancement, resource development (such as inventories of best practice), broad dissemination, training, and technical assistance.

Northwest Portland Area Indian Health Board

To address American Indian suicide in Oregon, Washington, and Idaho, the Northwest Tribes, led by the Northwest Portland Area Indian Health Board (NPAIHB), located in Portland, Oregon, initiated an inter-tribal action plan in January 2008 to guide program planning and catalyze effort. A resolution supporting the NW Tribal Suicide Action Plan was unanimously passed by the 43 members of the NPAIHB in January 2009. Coordinated and concerted effort is extremely important particularly to suicide prevention because of the systemic nature of the causes of suicide in Indian Country. For more information, visit *www.npaihb.org/health__*issues/suicide/

National Indian Child Welfare Association

Suicide occurs most frequently among adolescents and young adults with the seeds of the problem sown during childhood. Children are the principal and strategically important target population for suicide prevention. The National Indian Child Welfare Association (NICWA), located in Portland, Oregon, provides technical assistance and training to tribes, state and federal agencies serving children, removes barriers to accessing services, increases awareness of the risk factors that contribute to youth suicide in this population, and develops policy and strategies for increasing children's services and funding for tribes.

NICWA provided technical assistance to 49 SAMHSA-funded tribal communities under the tribal Systems of Care and Circles of Care since 1999. NICWA assisted two tribes in accessing Garrett Lee Smith Grants in 2008. NICWA has also secured funding from the American Legion Child Welfare Foundation, Inc. to develop and disseminate the *Ensuring the Seventh Generation: Youth Suicide Prevention Toolkit* for child welfare and mental health programs. The toolkit educates tribal child welfare workers on the warning signs of suicide, risk and protective factors, suicide prevention and intervention methods, and when such workers should seek professional mental health services.

Policy development activities include work on the reauthorization of the SAMHSA programming to address funding and programming in children's mental health for AI/AN youth, establishing a specific authorization for the tribal System of Care and Circle of Care grant programs, creating direct access for tribes under the Mental Health Block Grant and supporting the expansion of IHS funding under the Indian Health Care Improvement Act reauthorization to allow tribes to utilize System of Care concepts (i.e. child centered services, promoting systems collaboration and culturally competent) in IHS programs for youth. For more information, visit *www.nicwa.org*.

Native American Rehabilitation Association, Northwest, Incorporated

The *Native Youth Suicide Prevention* project, a three year grant award funded by SAMHSA for the second time, is a partnership between Portland, Oregon-based Na-

tive American Rehabilitation Association (NARA) of the Northwest, the nine federally recognized Tribes of Oregon, and Portland State University. The project increased community awareness through a media campaign with a focus on risk and protective factor education, provided evidenced-based *gatekeeper* trainings at Tribal and community locations, conducted culturally based prevention and wellness activities, developed community specific resource cards to strengthen the referral process, formed a Native American Elders Council for direction and wisdom, provided technical assistance including conference planning, identifying resources, coordination of stakeholder meetings, and evaluated effectiveness and progress of the project.

Portland State University Native American Community and Student Center

Universities and colleges are strategic points of intervention as students are at risk as well as being in training for careers that may include suicide prevention services. *Healing Feathers* is focused on American Indian/Alaska Native college students enrolled in Portland State University. The participants in *Healing Feathers* developed a brochure and power point presentation on warning signs of suicide, actions that individuals can take to provide support, and resources for referral and support. In the future the program seeks to establish a summer internship program working with the Native American communities in Oregon, both urban and rural to promote wellness and suicide prevention. The project uses community collaboration as a principal strategy.

Recommendations

Suicide is a devastating event for a family, a community, and a nation. Although the impact is powerful and widespread, suicide is a very individual event, often understandable only in retrospect, if ever. Expert professional intervention is critical for averting suicide by an individual who may be approaching such an act. A large increase in the number of such treatment "slots" and the expertise of interveners would avert significant numbers of suicides and reduce the devastating consequences for survivors.

However, important societal, community, family, and personal circumstances do affect an individual's propensity to suicide, and are reflected in the unusually high rates of suicide in *some* Alaska Native communities. (These circumstances also adversely affect other ills including substance abuse, crime, and failure to thrive and prosper.) Such circumstances can be changed. More programs to improve youth development; remove pathological community factors; and foster community self-determination, vision, and hope for the future would significantly reduce suicide and, further, greatly improve the well-being and productivity of an entire generation—the youth of today, the adults of tomorrow.

Carefully assessing individual interventions and community programs will facilitate continuing improvement of those interventions. However, we should not look to break-through improvements in behavioral technology. We already know the technology of suicide prevention pretty well. We just need a lot more of it, and we need to educate and train more personnel to deliver those interventions.

Our understanding and efforts are weak on some points. Although we have lists of best practices and strategic plan documents, the notorious *silo* problem, education and training shortcomings, and other factors have left us with a fractured approach to suicide prevention, full of working at cross-purposes, duplication, and unnecessary gaps. We need a systemic vision and inspiring leadership in order to bring together a concerted, coordinated effort. An emphasis in policy and investment on comprehensive vision, coordinated programming, and monitored and enforced collaboration from the highest levels to the front line would be helpful.

Following are the One Sky Center's observations on the state of suicide prevention in Indian Country and some more specific recommendations.

1. Policy and Administration

Findings: American Indian and Alaska Native (AI/AN) health needs are greater than the purview of the Indian Health Service or any other single federal agency. Comprehensive vision, inter-agency communication, coordination, and collaboration are essential. This is well known and multi-agency strategic plans, initiatives, agreements, etc., do exist. Interagency task forces, committees, coordination offices, and cross-agency staff placements have been employed to improve this situation.

However, comprehensive policy, communication, coordination, and collaboration are lacking. Fragmentation and dysfunction include, specifically, management by crisis, unnecessary gaps in service, duplications, working at cross-purposes, and inter-organizational competition. Of course, funding and staffing ("capacity") are vastly insufficient. At the front line, the impact of admin-

istrative and policy fragmentation is felt acutely and reflected in less than optimal services organization.

Recommendation 1.1: We recommend creation of an effective task force, office, or other at the HHS level to promote, monitor, and enforce comprehensive policy, communication, coordination, and collaboration on the federal response to AI/AN health needs.

Recommendation 1.2: We also recommend that a "blue ribbon" committee develop a comprehensive strategic plan for Indian Health care within the emerging National Health Care Reform initiative.

2. Community Competence

Findings: Research has demonstrated the "community competence" (ability to master challenges and meet the needs of community members) and ownership and control of local institutions and assets have a very large, measurable impact on suicide rates. These interventions are currently implemented on a small, pilot basis only.

Recommendation 2.1: We recommend extending and promoting programs like Native Aspirations (Kauffman and Associates, Inc.,) Nation-Building (Harvard University), and One Sky Center to mobilize and improve the strength of community institutions and leadership in identifying and mastering challenges within the community.

3. Youth and Family

Findings: Suicide is a chronic illness. The illness often begins in childhood and develops over years as a vulnerability, propensity, ability, and, finally, a determination to suicide. Providing opportunities to develop life skills, commitment to community service, and involvement with nurturing and shaping family relationships creates resiliency and capacity to meet the crises and challenges that otherwise precipitate suicide.

Recommendation 3.1: We recommend extending and promoting youth development and family strengthening programs across Indian Country.

4. Clinical Services

Findings: When screening, gate-keeping, school counselors, social workers, law enforcement/judicial authorities identify individuals with high suicide potential, they attempt to refer the suicidal individual to someone able to intervene. In fact, there is a massive lack of such individuals. Further, the capacity of staff of multiple agencies to collaborate in the care of such an individual is limited by lack of policy, procedure, and infrastructure support.

Recommendation 4.1: Increase the workforce of skilled clinical staff capable of providing suicide intervention services. This includes funding additional staff positions as well as workforce management efforts such as recruitment, retention, and infrastructure support.

Recommendation 4.2: Promote policy, procedure and infrastructure support at the community level for interagency coordination and collaboration in delivering services to individuals.

Recommendation 4.3: Institute telehealth services to support community front-line clinical staff with tertiary care expertise in assessment and treatment planning for suicidal patients.

5. Training and education of staff

Findings: Physicians, where available, are not always skilled in suicide risk assessment and intervention. Other professional staff also lack these skills and knowledge. Consequently, even those suicidal individuals who do gain access to professional help may not receive an effective intervention.

Recommendation 5.1: Establish cultural relevance in professional training curricula.

Recommendation 5.2: Increase on-the-job continuing education together with certification for AI/AN health care personnel.

Recommendation 5.3: Institute telehealth training services for on-the-job continuing education by professional colleges and universities.

6. Research

Findings: We all feel a profound ignorance in the face of so shocking an event as suicide. While there is a reasonably good understanding of the epidemiology and etiology of suicide and we have a large body of research on preventive and treatment interventions, a great deal of work is still needed. We lack

a good understanding of Culture-Based Interventions, a very challenging area of research. We also lack universal, systematic and continuous evaluation of suicide prevention and treatment interventions (and, therefore, the ability to continuously improve those interventions on the basis of such information).

Recommendation 6.1: We recommend innovative research on Culture-Based Interventions with mandates and financial support capable of progress on this challenging area of research.

Recommendation 6.2: We recommend a strong policy commitment to ongoing evaluation of all prevention and treatment services, together with utilization of that evaluation in program improvement. This recommendation is not new: for example, it is found in many accreditation programs.

Recommendation 6.3: We recommend that the practice of program evaluation and continuous program improvement be widely taught in professional schools and in continuing-education programs.

Conclusion

We commend Senators Dorgan, Barasso, and the Senate Committee on Indian Affairs for holding this hearing, requesting comment on this most important issue, and especially to the Oregon Delegation for their support on these issues, namely former U.S. Senator Gordon Smith (R–OR).

We would also like to recognize former U.S. Senate Majority Leader Tom Daschle (D–SD) who consistently fought to improve Indian health, and along with Senator Smith, crafted the tribal provisions for the Garrett Lee Smith Memorial Act that is now the authorizing statute for suicide prevention monies through the Substance Abuse and Mental Health Services Administration.

I had the good fortune recently to visit briefly with Senator Smith here in Washington when he was honored by the American Psychiatric Association and have been in contact with him since then. I informed him of this opportunity to testify today and although he let me know he wished he could be here, he passed on these words for me to share with you on this most important issue to both him and all of us here today:

> "The numbers of suicides among our Native American brothers and sisters, especially among the young, is a national tragedy, and ought to be a concern to all Americans. The Garrett Lee Smith Memorial Act is a vital tool in helping tribal governments to assure that, in the future, there are no more fallen feathers. The reauthorization and funding for Garrett Lee Smith Memorial Act couldn't be more urgent and important. It's part of keeping faith and represents a matter as grave as life and death."

The One Sky Center stands ready to assist the Committee on this issue, and we will hope to exist in our committed work.

Thank you very much. This concludes the written part of my testimony.

Attachments

Substance Abuse and Mental Health Services Administration

SAMHSA NEWS

SAMHSA's Award-Winning Newsletter September/October 2005, Volume 13, Number 5

Recovery Is Key for Mental Health Action Agenda

Marking a milestone in the history of mental health and mental illness in America, SAMHSA recently released *Transforming Mental Health Care in America—The Federal Action Agenda: First Steps.*

"As we mark the 15th anniversary of the Americans with Disabilities Act, the Action Agenda makes an important contribution for Americans with mental health-related disabilities," said Mike Leavitt, U.S. Secretary of Health and Human Services (HHS).

"The Action Agenda details the initial steps the Federal Government is taking to transform the form and function of the mental health service delivery system in America," said Secretary Leavitt. "HHS and its partners across the Federal Government are committed to a shared goal of collaborating to change fundamentally the way the Nation's mental health care system functions."

SAMHSA led the Action Agenda's development. The Agency aligned six cabinet level departments—Education, Health and Human Services, Housing and Urban Development, Justice, Labor, Veterans Affairs, and the Social Security Administration—in an unprecedented multi-year effort, which includes

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Katrina Response & Recovery

See page 19 for story

Tribes Weave Visions for Healthy Future

The third annual "National Behavioral Health Conference on Alcohol, Substance Abuse and Mental Health: Weaving Visions for a Healthy Future" held in San Diego, CA, in June drew more than 500 American Indian and Alaska Native substance abuse treatment and mental health practitioners, tribal representatives, traditional healers, health care providers, state program directors, consumers, and their families.

Co-sponsored by SAMHSA and the Indian Health Service, the conference was held to develop recommendations, stimulate discussion, and identify opportunities for collaboration and coordination of alcohol and substance abuse treatment and prevention efforts in Indian communities.

The 3-day conference was preceded by a forum on "Best Practices in Substance Abuse Treatment for American Indians and Alaska Natives," which highlighted several current or past SAMHSA grantees.

SAMHSA's Center for Substance Abuse Treatment (CSAT) sponsored the forum.

Dale Walker, M.D., a member of the Cherokee tribe and Director of the One Sky Center, emphasized the symbolism of the conference title. "Weaving our vision is so important in Indian Country," he said. "It's a bringing together of many different resources and efforts."

He explained, "It's like a two gray hills rug. In other words, the partnership is complementary in its ability to work together and produce positive results in the same way that the classic Navajo weave of a two gray hills rug is complementary in color, style, and strength. That should be our metaphor as a system of care reaching out into the Indian community."

The Directors of all three SAMHSA Centers addressed forum attendees, and SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W., and Indian Health Service (IHS) Director Charles W. Grim, D.D.S., M.H.S.A., both addressed the conference.

"You are on the cutting edge, on the frontier," said CSAT Director H. Westley Clark, M.D., J.D., M.P.H., to forum attendees. Dr. Clark acknowledged the current lack of evidence-based practices that apply to American Indians and Alaska Natives specifically. "Native communities need to ensure that they are included in research studies and clinical trials. Right now, you can't turn to the academic literature for the answers," Dr. Clark added. "The answers are within you."

SAMHSA's Center for Substance Abuse Prevention Director Beverly Watts Davis told forum attendees that the Agency's Fetal Alcohol Spectrum Disorders Center for Excellence is working on an American Indian and Alaska Native initiative that will focus on FASD in Indian Country.

In addition to recognizing program successes, the conference also recognized the recent tragedies at the Red Lake and Standing Rock reservations involving youth suicides. A multi-agency team including representatives from SAMHSA, IHS, state agencies, and the One Sky Center provided on-site assistance.

With special funding provided by SAMHSA through the One Sky Center, a panel of youth attended the conference to share their feelings about the crisis.

A. Kathryn Power, M.Ed., Director of SAMHSA's Center for Mental Health Services, told participants, "Suicide is robbing Native communities of their most valuable resources: their children and their future."

She acknowledged that a "serious challenge to achieving our goal is the current disparities of care—too few providers in remote locations." She also pointed to a "lack of cultural competency in our programs and provider training. We don't know enough about Native cultures and the differences between them," she said.

At both the forum and the conference, participants not only described substance abuse prevention and treatment programs and practices that are working, but also emphasized the common bonds that Native people share regardless of tribe. "Indian people don't see treatment and prevention as different," said Dr. Walker. "They see them as part of the same holistic system."

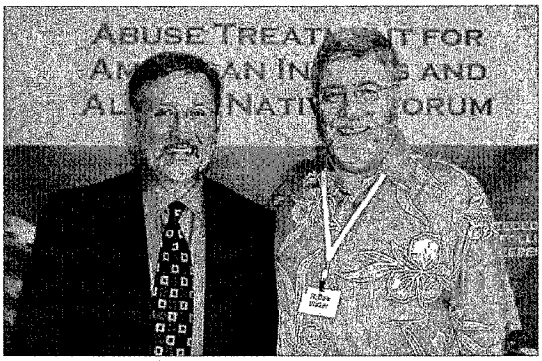


Photo by Meredith Hogan Pond

SAMHSA Administrator Charles G. Curie (left) and Dr. R. Dale Walker, Director of the One Sky Center, in Portland, OR, were in San Diego, CA, in June for the third annual behavioral health conference.

Photos by Meredith Hogan Pond

The American Indian and Alaska Native "Best Practices" forum included (left to right) Eva Petoskey, Inter-Tribal Council of Michigan; Linda Woods, Little Traverse Bay Band of Odawa Indians; Don Coyhis, White Bison, Inc.; McClellan Hall, National Indian Youth Leadership Project; Laverne Alexander, Tanana Chiefs Conference; Valerie Naquin, Cook Inlet Tribal Council; Jodi Trojan, Tanana Chiefs Conference; and Donald Charley, Old Minto Recovery Camp.

Common Themes

Common themes centered on how traditional Native cultures enhance substance abuse treatment and prevention; how important families are in the recovery process; how communities can heal; and how a vision of success can produce positive results.

"Alaska Natives are resilient people who take their resilience into their programs," said Valerie Naquin of the Cook Inlet Tribal Council. "Alaska Natives have survived thousands of years in some of the worst weather in the world." In developing Alaska Native best practices, she said, "We're a lot farther along than we thought we were. Many of our traditional practices are Medicaid billable now." These practices include walking on the tundra, gathering clams by the shoreline, berry picking, and the traditional steam bath, which is the Alaska Native version of the sweat lodge.

"Usually for grants you have to put in all the horrible things," said Ms. Naquin, who helps locate funding resources for the tribal council. "But we include stories and poems and describe the strengths in Alaska Native culture."

Eva Petoskey, a member of the Grand Traverse Band of Ottawa and Chippewa Indians in Peshawbestown, MI, has many years of experience in evaluation of substance abuse and prevention with rural reservation communities in the Great Lakes area. "Engaging people in evaluation can be part of community healing," she said. "It's important to bring people in when you have the opportunity—members of the community, the tribal council, consumers."

To honor the traditional spiritual basis for change, Ms. Petoskey starts all her evaluation sessions with ceremony and prayer. "Prayer is a healing process," she said. "Prayer helps with your work because we are walking with our ancestors, walking in mutual respect."

The best way to formulate outcomes is to start in a special sacred place," said Ms. Petoskey. "And it's important to feed people who participate in a focus group or survey," she added, "then people will want to be there."

"We know that culture is prevention," said Don Coyhis, a member of the Mohican tribe and president of White Bison, Inc., in Colorado Springs, CO. "When we turn to our Native culture, there are no suicides, no meth, no alcohol. When we start talking about our communities as healthy communities with sober leadership, then our communities are ready to mobilize."

The success of traditional practices in the recovery process was described by Laverne Alexander of the Tanana Chiefs Conference in Fairbanks, AK. "The Old Minto Recovery Camp is unique," she said. "Because entire families come together for the healing of addiction." Old Minto's goal is to bring people back to their culture. "The camp brings us back to our roots, brings us back together as a community, where we started," she said. "The emphasis is on subsistence living and gathering in traditional ways."

Another successful Native program guided by traditional Native values is Project Venture, based in Gallup, NM. McClellan Hall is executive director of Project Venture's National Indian Youth Leadership Project. The national Model Program develops healthy and resilient youth and community through leadership, service, and challenge. Activities focus on developing team building, problem solving, and cooperation skills through the use of experiential games and outdoor adventures including mountain biking.

"In order to be strong in your life, you need a vision of success. You have to be able to see it to believe it," said Iris Heavyrunner, M.S.W., a member of the Blackfeet tribe and a Ph.D. candidate in social work at the University of Minnesota. "Once you have a vision, you have a clear expectation of yourself. Students who graduated from college, for example, told me they could see themselves walking across the stage and reaching their hand out for their diploma. That's how clear their vision was. A vision is powerful." ◗

—By Meredith Hogan Pond

Tribes, Providers, Agencies Look to One Sky Center as National Resource

The One Sky Center, funded by SAMHSA, is the very first National Resource Center for American Indians and Alaska Natives dedicated to improving prevention and treatment of substance abuse and mental health disorders.

"This is a unique center," said Michelle Singer, a member of the Navajo tribe and communications coordinator for One Sky. "The Center is for—and created by—Native people."

The Center's Director, R. Dale Walker, M.D., is a member of the Cherokee tribe and professor of psychiatry at the Oregon Health & Science University (OHSU)—One Sky's home base in Portland, OR. "We want to be more than a listening post," said Dr. Walker. "We actively respond to requests for prevention- and treatment-related technical assistance from tribal organizations around the country."

What does "One Sky" signify? "For us, all Indian Nations and people are under one sky on Mother Earth," said Ms. Singer.

Accordingly, an important part of the One Sky Center's work is building networks and coalitions and fostering relationships with both tribal and non-tribal entities—in academia, the private sector, and Government—with the goal of promoting healing among individuals, families, and communities.

"Working with stakeholders from across the country, the One Sky Center provides a blueprint for comprehensive services that honor the traditional ways of living and healing among Native Americans," said SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W.

For example, One Sky's national reach has been enhanced and extended by its partnerships with several Native programs including the Alaska Native Tribal Health Consortium, and the Cook Inlet Tribal Council.

SAMHSA's Center for Substance Abuse Treatment (CSAT) and Center for Substance Abuse Prevention (CSAP) jointly fund the One Sky Center in a 3-year cooperative agreement with OHSU that began in summer 2003.

Photo by Jon Blackford

The One Sky Center helped bring together tribal leaders, traditional healers, and others for a day of sharing Native program success stories and lessons learned in an all-day forum before the start of the third annual Indian Health Service/SAMHSA conference in San Diego this June. (See *SAMHSA News*, page 10.)

Now beginning its third year, the Center continues working on its three main objectives:

- Promote and nurture effective and culturally appropriate substance abuse prevention and treatment services.
- Identify culturally appropriate and effective evidence-based substance abuse prevention and treatment practices and disseminate them so that they can be applied with relevance across diverse tribal communities.
- Provide training, technical assistance, and products to expand the capacity and quality of substance abuse prevention and treatment practitioners serving this population.

In 2 years, the Center has visited more than 100 communities around the country and provided many products and resources for Native organizations. "What we've really done is talk to the communities so we can modify the resources to fit community needs," said Dr. Walker.

In an effort to promote effective and culturally appropriate prevention and treatment, the One Sky Center has an online Native Programs Directory that hightlights programs funded by CSAT and CSAP.

The One Sky Center also receives funds from SAMHSA's Center for Mental Health Services. With this funding, the One Sky Center is continuing to develop an online American Indian/Alaska Native resource database for mental health prevention programs. The goal is to create a resource directory for dissemination to schools around the country with substantial American Indian and Alaska Native enrollment.

In the coming year, suicide intervention and prevention will be an increasing part of One Sky's work. "There is no way we can leave that out," said Dr. Walker, "because of its deep interrelation with all the other health care problems. We have to look at the whole concept of disease—or *dis-ease*—in the Native communities."

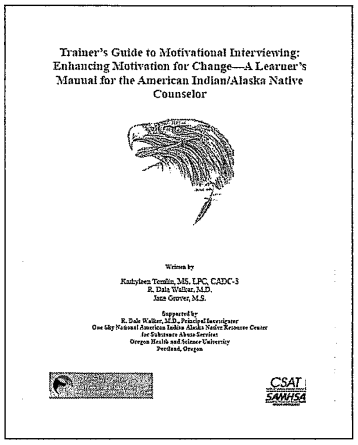
"Tribal programs, tribes themselves, and American Indians and Alaska Natives across the country actually have enriched understandings of how to recover and how to avoid and step away from illness," said Dr. Walker. "We need to include that knowledge in evidence-based practices."

One Sky's Web Site

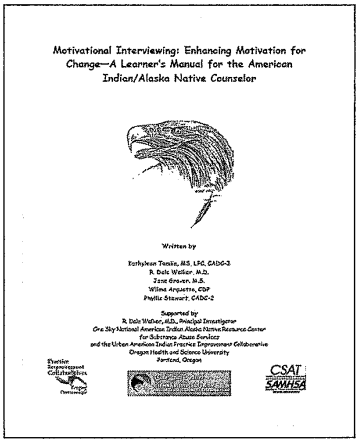
The One Sky Center's Web site offers downloadable newsletters, monographs, training manuals, directories, and congressional testimonies as well as several new information packages for all Indian communities. To order publications, contact the Center by email to onesky@ohsu.edu or phone (503) 494-3703. For more information, visit the Center's Web site at **www.oneskycenter.org.**

—By Meredith Hogan Pond

One Sky Center Products
(Available online at www.oneskycenter.org)


Trainer's Guide to Motivational Interviewing: Enhancing Motivation for Change—A Learner's Manual for the American Indian/Alaska Native Counselor
Written by
Kathyleen Tonsin, MS, LPC, CADC-3
R. Dale Walker, M.D.
Jane Gover, M.S.
Supported by
R. Dale Walker, M.D., Principal Investigator
One Sky National American Indian Alaska Native Resource Center
for Substance Abuse Services
Oregon Health and Science University
Portland, Oregon
CSAT
SAMHSA

Motivational Interviewing Trainer's Guide
103 pages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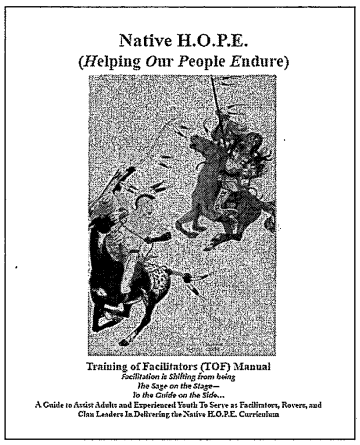
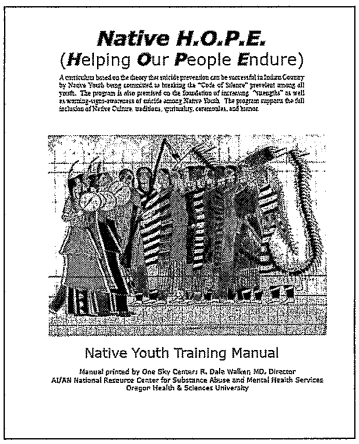
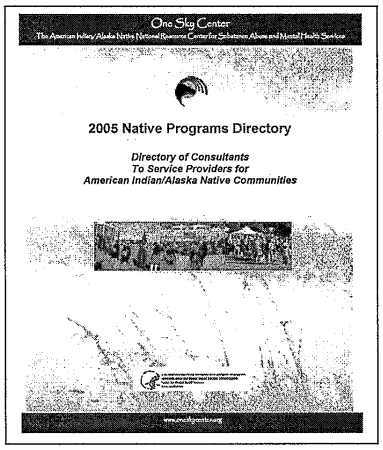
Motivational Interviewing Learner's Manual
125 pages


Native H.O.P.E.
(Helping Our People Endure)
Training of Facilitators (TOF) Manual
Facilitation is Shifting from being
the Sage on the Stage—
to the Guide on the Side...
A Guide to Assist Adults and Experienced Youth To Serve as Facilitators, Rovers, and Clan Leaders In Delivering the Native H.O.P.E. Curriculum

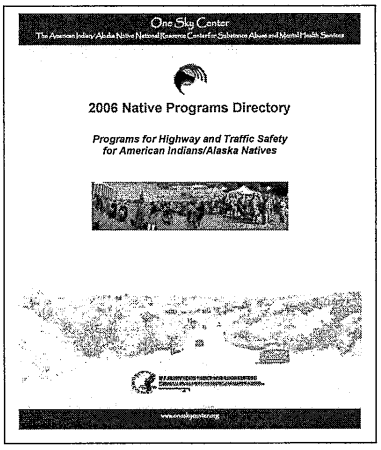
Native HOPE Training of Facilitators
67 pages


Native H.O.P.E.
(Helping Our People Endure)
Native Youth Training Manual
Manual printed by One Sky Center: R. Dale Walker, MD. Director
AI/AN National Resource Center for Substance Abuse and Mental Health Services
Oregon Health & Sciences University

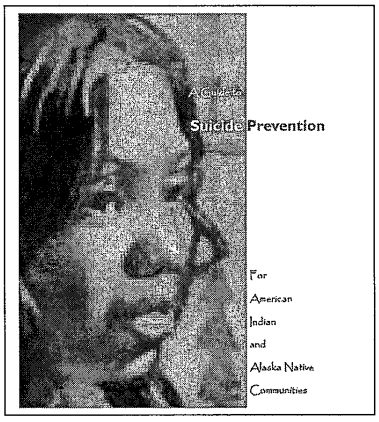
Native HOPE Youth Training Manual
83 pages



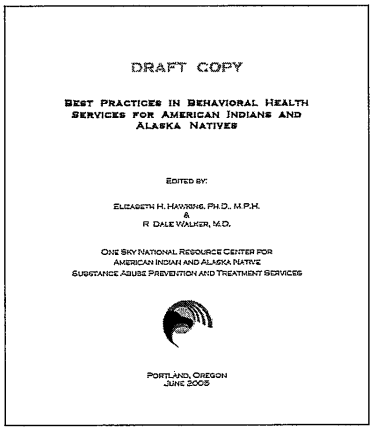
Directory of Consultants, 23 pages


One Sky Center
2006 Native Programs Directory
Programs for Highway and Traffic Safety
for American Indians/Alaska Natives

Directory of Highway and Traffic Safety Programs, 36 pages



Guide to Suicide Prevention, 96 pages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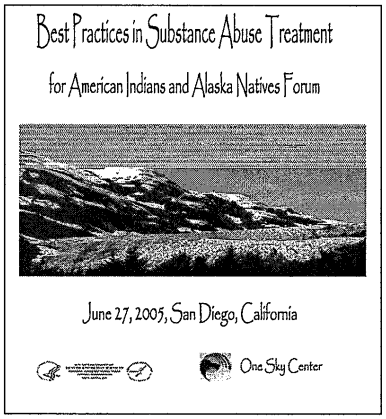
BEST PRACTICES IN BEHAVIORAL HEALTH SERVICES FOR AMERICAN INDIANS AND ALASKA NATIVES
EDITED BY:
ELIZABETH H. HAWKINS, PH.D., M.P.H.
&
R. DALE WALKER, M.D.
ONE SKY NATIONAL RESOURCE CENTER FOR
AMERICAN INDIAN AND ALASKA NATIVE
SUBSTANCE ABUSE PREVENTION AND TREATMENT SERVICES
PORTLAND, OREGON
JUNE 2005

Best Practices in Behavioral Health Monograph, 194 pages


Best Practices in Substance Abuse Treatment
for American Indians and Alaska Natives Forum
June 27, 2005, San Diego, California
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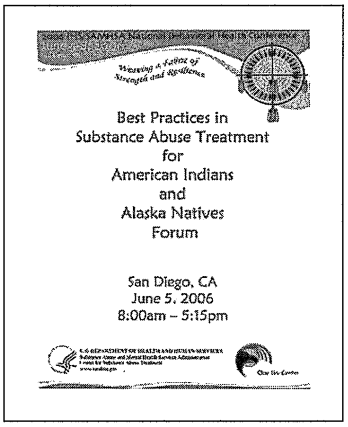
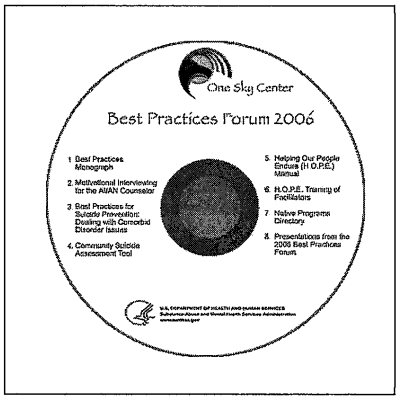
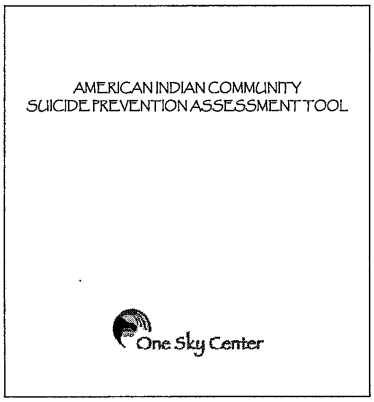
Best Practices Meeting, 2005, 140 pages



Best Practices Meeting, 2006, 272 pages


One Sky Center
Best Practices Forum 2006
1. Best Practices Monograph
2. Motivational Interviewing for the AI/AN Counselor
3. Best Practices for Suicide Prevention: Dealing with Comorbid Disorder Issues
4. Community Suicide Assessment Tool
5. Helping Our People Endure (H.O.P.E.) Manual
6. H.O.P.E. Training of Facilitators
7. Native Programs Directory
8. Presentations from the 2006 Best Practices Forum

Best Practices CD, 2006



American Indian Community
Suicide Assessment Tool, 20 pages

The CHAIRMAN. Dr. Walker, thank you very much. Thanks for your work, Dr. Walker, and I appreciate your being here once again before our Committee.

Next, we will hear from Mr. Hayes Lewis, Director of the Center for Lifelong Education at the Institute of American Indian Arts in Santa Fe, New Mexico.

Mr. Lewis, you may proceed.

STATEMENT OF HAYES A. LEWIS, DIRECTOR, CENTER FOR LIFELONG EDUCATION, INSTITUTE OF AMERICAN INDIAN ARTS

Mr. LEWIS. Thank you, Mr. Chairman and members of the Committee. It is a pleasure to be here.

My name is Hayes Lewis. I am the Director for the Center for Lifelong Education and from Zuni Pueblo.

I would like to talk today about my experiences as a school superintendent in the State of New Mexico at the Zuni Pueblo School District and what we did to overcome the youth suicides in our tribal community, but also talk about the responsibility that all community leaders have, as well as tribal colleges, in assisting tribes to build the capacity and strengthen the capacity to deal with these kinds of public health issues in their communities.

As a school superintendent, and one of the reasons why we created our own school district, was because of many dysfunctional conditions and the lack of educational opportunity that was evident as part of the Gallup-McKinley County School District. So we broke off and in 1980 created our own system. One of the first things that we addressed was a long-term condition of youth suicides in our tribal community.

For a while there, we were averaging about two a year, and it was an emotional roller coaster, particularly when you have a tribal community where nearly everybody is related by blood or by clan or by society in some way. So dealing with that, we called in some assistance from the Indian Health Service, particularly from Stanford University. Teresa LaFromboise is one of the key people that helped us.

By putting a focus on youth suicide and by our tribal council and all the tribal organizations, including the schools, making the commitment to enhance life and to take the responsibility of saying this is our problem, you know. We can have all of the experts come into our tribal communities, but unless we decide and we own the problem, then nothing happens.

And so we went through the process of mobilizing our community and developed the school-based program, culturally based because one of our chief referrals was to tribal traditional healers. While that is a family responsibility, we did everything we could to make that a flexible option for them. But more importantly, the school and the school boards really decided that this is a priority. These are the kinds of systems that we are going to put in place, protocols. So our youth suicides ended for quite a number of years.

But just as Zuni has, as have other tribes, slipped back into seeing more youth suicides in the community again, I think this just points to the fact that it is a very fragile situation and one that always have to be reinforced in a number of ways by tribal leaders.

So we look forward to the day when tribal leaders, school leaders, can stand up and say we are going to create safe schools. We are going to create safe communities so that all children and people and members will benefit from this. And so it does take that kind of a commitment.

In terms of tribal colleges, the Center for Lifelong Education does not receive any monies from, with the exception of a small $5,000 grant from the State of New Mexico Youth Suicide Prevention Coalition. But we work in concert and collaboration with the New Mexico Youth Suicide Prevention Coalition to provide free technical assistance, workshops. We use people that have extensive experience in the communities, to start spreading the story, spreading the news about youth suicide is preventable. There are certainly re-

sources that are available nationally and statewide, as well as within our tribal communities, that can bring to bear their talents and expertise to deal with this crisis.

So our focus is really in strengthening tribes, strengthening communities to create the capacity to deal with these kinds of issues and concerns from the internal, and strengthening those resources that they know they have within the community and building relationships so that they can use others as well.

The recommendations I have listed for you are very important in my mind, but at the same time, in listening and thinking about what is going on in New Mexico now, we really need to look at developing programs at the graduate level as part of the education for teachers and administrators that need to really develop and enhance their cultural competency about particularly Indian situations. But more than that, that they are there for service to all of the children and that schools become safe, just as communities become safe.

So I will end my presentation at that. You have my testimony. I really appreciate the time and the commitment all of you have made to ending youth suicide in Indian Country.

Thank you.

[The prepared statement of Mr. Lewis follows:]

PREPARED STATEMENT OF HAYES A. LEWIS, DIRECTOR, CENTER FOR LIFELONG EDUCATION, INSTITUTE OF AMERICAN INDIAN ARTS

Good Morning Mr. Chairman and members of the committee. I appreciate the opportunity to present testimony on a topic of grave importance in Indian Country-that being the extremely high rates of youth suicide among Native American youth.

My name is Hayes Lewis. I am an enrolled member of the Zuni Tribe. Presently I serve as the Director for the Center for Lifelong Education at the Institute of American Indian Arts in Santa Fe, New Mexico.

Today, I want to provide an overview of the Zuni Pueblo efforts to reverse a long term trend of youth suicides. I will also highlight the status of prevention activities in New Mexico then briefly review our activities and commitments as tribal colleges to assist tribal communities strengthen their capacity to address critical challenges, and then offer some recommendations to effectively address youth suicide within tribal communities.

The Institute of American Indian Arts (IAIA) is the only congressionally chartered tribal college in the United States. Our academic and arts programs are accredited by the Higher Learning Commission of the North Central Association and the National Association of Schools of Arts and Design.

We serve students from 80 tribes, 23 states, international students and students from area public, private and Bureau of Indian Education high schools. IAIA offers AA, BA and BFA degrees in Studio Arts, Creative Writing, Museum Studies, New Media Arts as well as Indigenous Liberal Studies.

The Center for Lifelong Education provides custom designed training and technical assistance in nine programmatic areas along with extended academic and outreach training opportunities through distance education, applied research and cultural exchanges. We provide services to Indigenous nations and tribal communities regionally, nationally and internationally.

I want to acknowledge the work of all of my colleagues and especially those community members who are on the ground in our Pueblos, our reservation and urban tribal communities and daily work to strengthen our people through their care, skills and efforts.

After conducting these hearings over the years, you are likely to have a grasp of the magnitude and complexity of the issues and current statistics associated with youth suicide.

Over the years a number of promising practices have emerged. Some of these have been community driven initiatives, there have been a number of policy and funding initiatives within the Indian Health service and other national agencies. There have also been legislative initiatives and support at the state and federal levels.

A Promising Practice: Zuni Life Skills Development Program

I am very pleased and grateful for Dr. LaFromboise presence on the panel today. She has spent many years examining the issues of youth suicide in Indian Country, but more importantly, she is a valuable resource to tribes to assist in their efforts to design appropriate prevention programming to end youth suicide.

During my tenure as Superintendent of the Zuni Public School District, I requested that she and her team of experts from Stanford University come to Zuni to assist our community experts to design a culturally based youth suicide prevention and intervention program and curriculum.

Three years were invested in community based research, designing a culturally based approach to address suicide, awareness building and training, refining life skills teaching/learning approaches and plans, meeting with parents, consultation with the Zuni Board of Education and Zuni tribal council, designing and deploying identification and referral procedures, and mobilizing community inter-agency effort in a focused manner to stop youth suicides.

When we had a viable prevention and intervention plan and program in place-the suicides stopped. A long term historical trend had been broken and the page was turned to a new, life enhancing chapter of experiences for the Zuni community and youth.

The strength and viability of the Zuni Life Skills Development Program is evident in the longevity of the impacts in the Zuni community and a track record of over fifteen years where there were no youth suicides in Zuni.

The weakness has been that local policy makers, community agencies, school administrators and the tribal council members forgot how fragile the peace was-they rationalized that since we had not had a youth suicide in years-the problem was solved. The curriculum was relegated to a shelf in the library and the hard gained experience and the value of lost lives was forgotten. The warning signs within the community have been evident for a number of years and recently, the suicides returned.

What did we learn?

Suicide prevention and intervention requires constant vigilance and appropriate action at many levels. This requires a collective energy, commitment, careful orientation, focused training, community awareness, school and community collaboration strategies, and the creation of effective, culturally responsive policies and protocols. The Zuni school administration and board decided that the energy expense and effort was no longer a high

priority, and this effectively stopped the progress to the second stage of community empowerment.

The fact that this did not occur can be traced back to three important reasons: 1) the lack of acknowledgement and acceptance by key community individuals that suicide represented a serious health and safety threat to the entire Zuni community, 2) ineffective tribal and community leadership and advocacy for the health and safety of tribal members, and 3) a decline in collaboration locally and with national health services agencies and resources to address suicide and related issues in systemic and proactive ways.

On a more positive note, we know that the experience and success of the Zuni Life skills Development Program (ZLSDP) gave rise to the American Indian Life Skills Development Program which is available through Stanford University to any tribe or community that are searching for a template for effective suicide prevention and life enhancing programs.

The curriculum and program effectively stops or reduces the incidence of youth suicide when implemented in coordination with tribal/community leadership, parents, students, local and national health services providers.

There has been a rise in youth suicides nationally, so we must continue the search for meaningful options such as the ZLSDP to address this public health crisis. In our search for solutions we must be guided by our success as well as our failures, and learn from each experience.

Youth suicide is preventable

Youth suicide in Indian country is preventable. However the task of positively and proactively ending youth suicide in tribal communities, will require a number of changes of perspective regarding what can and must be done.

Too often, tribes and supporting community agencies, schools and school districts have not taken the initiative to develop proactive strategies to comprehensively address health and safety issues and challenges in a holistic manner. This is not to say that there is a lack of concern or effort, rather there seems to be a lack of priority along with a piecemeal approach which impacts the overall analysis, design and implementation of community based prevention strategy and programming.

Dr. Richard Carmona, U. S. Surgeon General stated previously that "among tribal populations, suicide is not an individual clinical condition, but also a community clinical condition".

I truly believe this to be the case and while we recognize the debilitating impacts of historical trauma and other environmental causes that represent limitations and promote dependency among our people, we must go well beyond this discussion and critically

think about ways to demonstrate leadership as well as our individual and collective responsibility to create safe, life enhancing tribal communities.

Until we move to a discussion about the collective tribal loss represented by a single suicide, we will not fully engage the reality that our communities need to be healed in many ways. In this realization we then may find the courage to discuss openly and respectfully the value that a single life represents to the whole, and that self-inflicted death is not acceptable.

In my experiences working in my community, I have witnessed the numbness that results from parents unable to understand why their child took their own life? What went wrong? In their grief they have lashed out at their neighbors, other relatives and even blamed themselves for the death of their son or daughter. The continual loss of life due to suicide adds an immense burden and stress on everyone, particularly the survivors.
There must be a focused community effort, led and supported by the tribal government to comprehensively address the grief and pain of the community, so healing may begin.

Many of our Native American youth attend off reservation public school districts that have demonstrated little sensitivity to their needs, issues and cultural values. School administrators working in public schools serving Indian populations are so bent upon meeting the high stakes demands of testing and Adequate Yearly Progress (AYP) that they have no time to do more than the minimum expected when it comes to responding to the emotional and cultural needs of Native American students. All of these amounts to a message: I'm sorry, but I don't have time for you-you don't count.

The New Mexico Suicide Prevention Activities

A number of important developments have occurred in New Mexico as related to the prevention of youth suicide. While New Mexico has consistently ranked among the top five states for suicide rates in the United States with a rate of between 1.5 to 2 times the national averages, the state has developed a consistent process that maximizes its scarce resources to support all communities to address the challenges of preventing youth suicides.

The creation of the New Mexico Suicide Prevention Coalition has accomplished much to create awareness, provide resources and assist communities tribal and non-tribal to work toward the prevention of youth suicide.

Over the past two years the Center for Lifelong Education has participated as a coalition member and supported coalition efforts by providing workshops and training to tribal and non-native community members, students and service providers in awareness, prevention and capacity strengthening using culturally based approaches to planning and community mobilization.

By prioritizing resources and proactively developing collaborations with tribal communities, the New Mexico Public Health Department has demonstrated that it has a

stake in promoting the development of locally developed approaches to meet this extraordinary public health challenge.

Role of tribal colleges in promoting tribal capacity building

Most tribal colleges are at the forefront of interactions with tribal communities. They serve as a valuable resource to intergenerational populations and are available to contribute to the enhancement of tribal capacity and sustainability in areas such as youth suicide and to enhance community health and safety.

The Institute of American Indian Arts takes its role and responsibility to the nineteen Pueblos, Navajo and Apache Nations in New Mexico very seriously.

By initiating the Center for Lifelong Education, IAIA extended its outreach and technical assistance to tribes and has become known as a dependable resource and advocate serving area and regional tribes in a number of critical areas to include suicide prevention. I am attaching a copy of a news article along with a copy of our last youth suicide prevention conference.

Recommendations

I respectfully offer the following recommendations to strengthen tribal capacity to address the health and safety of community members based on our work, experiences and observations.

Make a commitment to designing a unified community wide strategy to enhance life and prevent youth suicide.

In tribal communities in the southwest, the experience at Zuni Pueblo, Dulce (Jicarilla Apache) and White Mountain Apache in youth suicide prevention demonstrate how the dynamics of community perceptions and disability are changed when tribal/community leadership make a commitment to unified, community based action.

Develop comprehensive community plans that address the complex issues that impact youth at home, in the community and the schools.

In Developing a comprehensive action strategy and plan to address the challenges faced by youth we must consider that the challenges of youth today are much more complex than in our day. Not only do today's youth have to contend with social and economic challenges, they must also contend with the fear of other violent behaviors such as bullying in all of the contemporary contexts: cyber bullying, cell phone bullying, racism, homophobia, gang activity.

Tribal and community leaders must take the lead in supporting the establishment of safe and healthy communities.

There also must be a commitment to continue prevention and safe community practices and protocols in a consistent manner when such protocols are established. Tribal leaders must initiate policy that will bring all partners to the table to discuss options and create opportunities to establish safer and healthy communities.

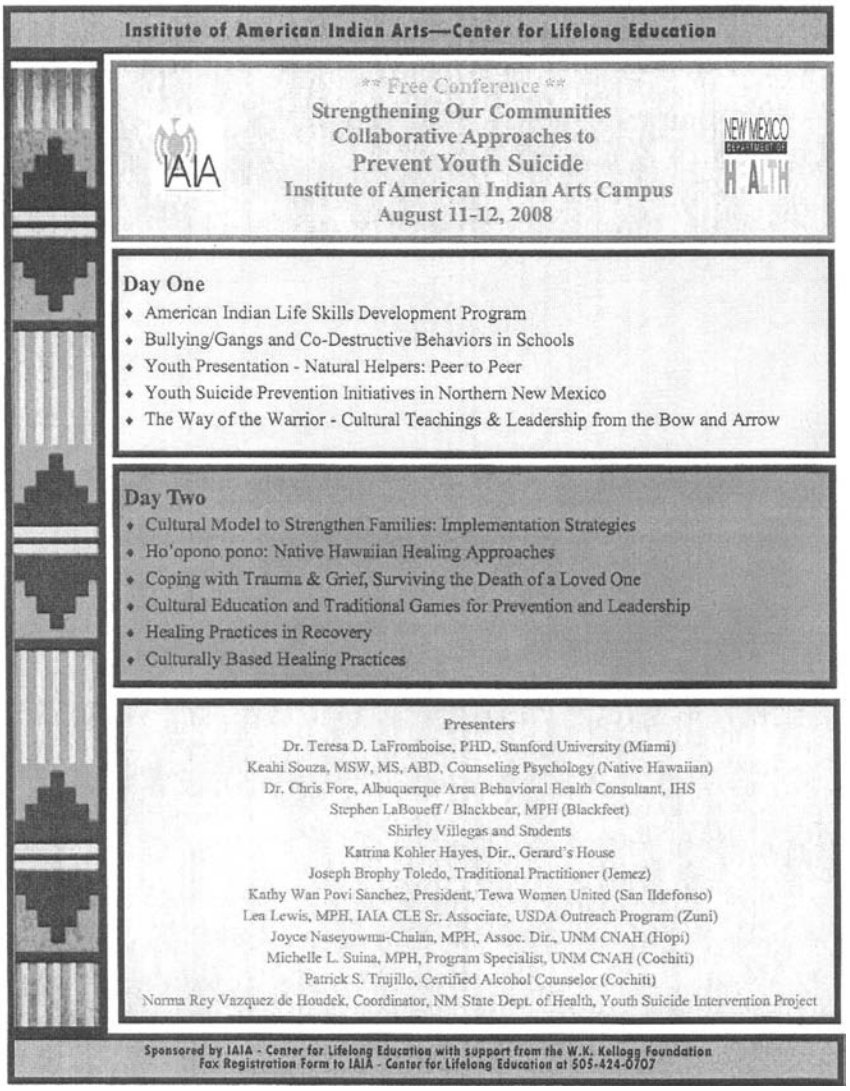
Schools and public districts serving Indian populations must be held accountable and responsive to tribal prevention plans.

School officials and decision-makers must become partners with tribes to promote tribal strategies and prevention needs. This means systematic and meaningful consultations on a regular basis with tribal and community leadership. Not just during a crisis.

Provide funding to support training to enhance tribal capacity to address youth suicide.

This may be accomplished in several ways. Provide funds to agencies such as the NM Suicide Prevention Coalition, to tribal colleges, directly to tribes and /or to agencies such as the Indian Health Service. Many of the service providers and front line workers in our communities are tired of the crisis-response-intervention-dependency syndrome faced by many tribal communities when interacting with outside of community agencies. Under such stressful circumstances, knowledge transfer is not optimal and the feelings of inadequacy and dependency are heightened. Make funds/grants available to tribes with requirements that include stronger collaborations, the design of holistic strategies, training and knowledge transfer.

Thank you for providing this opportunity.



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- Youth Presentation - Natural Helpers: Peer to Peer
- Youth Suicide Prevention Initiatives in Northern New Mexico
- The Way of the Warrior - Cultural Teachings & Leadership from the Bow and Arrow

Day Two

- Cultural Model to Strengthen Families: Implementation Strategies
- Ho'opono pono: Native Hawaiian Healing Approaches
- Coping with Trauma & Grief, Surviving the Death of a Loved One
- Cultural Education and Traditional Games for Prevention and Leadership
- Healing Practices in Recovery
- Culturally Based Healing Practices

Presenters

Dr. Teresa D. LaFromboise, PHD, Stanford University (Miami)
Keahi Souza, MSW, MS, ABD, Counseling Psychology (Native Hawaiian)
Dr. Chris Fore, Albuquerque Area Behavioral Health Consultant, IHS
Stephen LaBoueff / Blackbear, MPH (Blackfeet)
Shirley Villegas and Students
Katrina Kohler Hayes, Dir., Gerard's House
Joseph Brophy Toledo, Traditional Practitioner (Jemez)
Kathy Wan Povi Sanchez, President, Tewa Women United (San Ildefonso)
Lea Lewis, MPH, IAIA CLE Sr. Associate, USDA Outreach Program (Zuni)
Joyce Naseyowma-Chalan, MPH, Assoc. Dir., UNM CNAH (Hopi)
Michelle L. Suina, MPH, Program Specialist, UNM CNAH (Cochiti)
Patrick S. Trujillo, Certified Alcohol Counselor (Cochiti)
Norma Rey Vazquez de Houdek, Coordinator, NM State Dept. of Health, Youth Suicide Intervention Project

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"I Wish I Would Have..." H. Clay Napie, Jr. Dine

"As a Native American photographer, I feel it is important to show what the issues are on the reservations. Suicide is one of the biggest problems, because more and more Native Americans are giving up on life. Suicide has taken away three of my relatives in the last five years: my uncle Teddy Castiano, Jr., my cousin Shani Castiano, and my cousin Nehemiah Castiano. I realized, through this experience, that you can be hanging out and talking to loved ones one day, and then the next day may be the saddest day of your life because they are gone. I did this project because I wanted people to know that losing a loved one to suicide is hard, but I also wanted to show my respect to each of them and remember them for who they were in life - and how important they were to my family. I don't know why they chose to end their lives, but I did this series of photographs to pay tribute to them and their memory. This project was extremely hard to do these past semesters, but it also started me on a road toward healing. As a Native American photographer I feel that it is important to get this type of work out there and, hopefully, raise awareness and create discussion about suicide"

Strengthening Our Communities: Collaborative Approaches to Prevent Youth Suicide
Jaime Gaskin Eyrich, Program Development Officer
Center for Lifelong Education, IAIA

A sobering and disturbing fact of life in Indian Country is a higher-than-average suicide rate among Native youth: a staggering 2.4 times the national average for youth 15-24 years of age. The State of New Mexico is ranked number five in the United States for total suicides. In order to bring further awareness to issues of suicide in New Mexico Pueblos and surrounding communities, a symposium aimed at preventing youth suicide was held at IAIA on August 11-12, 2008.

Approximately one hundred representatives from Pueblo communities, middle and high schools, universities, and medical institutions were in attendance. Along with experts in the fields of youth suicide, destructive behavior prevention, and gang violence/bullying, a powerful presentation by young peer counselors from Pojoaque Valley High School showed us how students can help stem the rising tide of violence and self-inflicted harm. Native behavioral experts and counselors highlighted the power of prayer and traditional healing practices, and the importance of family and community in the well-being of our youth.

PICTURE
Keahi Kimo Souza
School Social Worker, Native American Community Academy

PICTURE
Teresa LaFramboise
College of Education, Stanford University

The event was sponsored by the Center for Lifelong Education, in collaboration with the NM Department of Health, Office of School & Adolescent Health - Youth Suicide Prevention, and with support from the W. K. Kellogg Foundation.

The CHAIRMAN. Mr. Lewis, thank you very much.

And finally, we will hear from Dr. Teresa LaFromboise, Associate Professor, Stanford University School of Education.

STATEMENT OF TERESA D. LAFROMBOISE, PH.D., ASSOCIATE PROFESSOR OF COUNSELING PSYCHOLOGY AND CHAIR OF NATIVE AMERICAN STUDIES, STANFORD UNIVERSITY

Ms. LAFROMBOISE. Good morning. Thank you for the opportunity, Chairman Dorgan and members of the Committee, for me to be able to present a little of my experience in working in the area of Indian youth suicide. I am a Professor of Counseling Psychology,

the mother of an enrolled member of the Turtle Mountain Ojibway Tribe, the developer and evaluator of the Indian life skills curriculum that Mr. Lewis talked about.

I research in the area of ethnic identity and mental health, and I was a former elementary and secondary teacher in urban and reservation schools. So I am glad that there are some educators at the table, too.

I believe I was asked to talk some about the progress that I have seen made since the hearings that were held by this Committee in the past to document the extent of the problem of Indian youth suicide. I thought that maybe I would be additive in that way.

As a result of some of the funds that have been appropriated through the Garret Lee Smith Memorial Act, I was able to work directly with a few of the SAMHSA programs for Indian youth suicide: one with Native Aspirations in which we developed regional training programs. In one year, we trained groups of three from 30 reservations in Wolf Point, Montana; Rosebud, South Dakota; Pine Ridge, South Dakota; and Anchorage, Alaska.

I also worked with the Indian Country Child Trauma Center at Oklahoma University, where they helped support the development of a middle school version of the American Indian Life Skills curriculum, which we field tested on the Omaha Reservation.

And then finally, the third SAMHSA project I was able to work with was with the Puyallup Tribe with their Helping Hands Project, where we worked with the mental health technicians from the tribal health authority, and six grade teachers from Chief Leschi School, to facilitate the field testing of the middle school version of American Indian Life Skills.

So all in all, of these wonderful experiences, I have met an incredible number of native people who are wonderful interventionists. I certainly have witnessed the power of traditional healing when it is used in conjunction with effective psychological practices. Traditional healing effects its own power, but it certainly helps accentuate what psychological services can be done.

I have also encountered a lot of frustration on the part of tribal leaders at the slowness with which we have been able to get these programs out. There are a number of programs that are highlighted in the special report of the Institute of Medicine and other evaluations of Indian-specific programs for suicide prevention. Dr. Walker's approach is one. The Zuni Life Skills Program is another. And there is a wonderful program entitled The Western Athabaskan Natural Helpers Program where we have direct evidence of the effectiveness of those programs in reducing hopelessness and reducing suicidal ideation, and also strengthening the skills of youth to help their friends talk about their problems and get them to help. Getting them to someone for help is the main thing.

But I have also really come to appreciate the fact that many of these programs privilege traditional ways of knowing. They encourage youth to be involved in their cultural practices. They involve tribal leaders and resilient elders in those practices. And that relationship shouldn't be overlooked because we do have research that talks about the impact of being embedded in one's culture, being embedded, and how that is very positively associated with protec-

tive factors, such as academic success, and negatively associated with depression. So in other words, it really helps overcome depression.

Now, what I would like to add to this conversation, perhaps, is the fact that I have just finished working on a committee at the National Academy of Sciences. As you probably know, a report has just been shared, and there will be public dissemination of it very soon, entitled Preventing Mental, Emotional and Behavioral Disorders Among Young People.

This report emphasizes a number of evidence-based programs for families, school and community interventions. We know that a number of the risk factors for suicide are risk factors common for other kinds of problems such as substance abuse, unsafe sex, even eating disorders. This report highlights a number of those.

Unfortunately, most of the studies outlined in the report have been conducted in mainstream populations and mainstream society. Some of those interventions have been evaluated in primarily African American and Latino/Latina populations, but very few with Native Americans. There is only one with Native Americans that I know of.

What I am suggesting as a recommendation, when we talk about advancing funding, is that there be evaluations of the effectiveness of these interventions in Indian communities. If they are found not to be generalizable, if they are not generic enough to be appropriate within Indian communities, then do not require communities receiving Federal funding to have to use them.

I am suggesting that technical assistance centers, like the Institute for American Indian Arts, Center for Life Long Learning, or the One Sky Center, or even a new one, and the work that has been done at Native Aspirations, could provide opportunities for native researchers and clinicians to work with noted prevention researchers around adapting these evidence-based interventions so that they will be culturally sensitive and so that they will be more widely accepted among communities. I think that tribes do not want the transposition of one intervention that works supposedly for all onto their communities.

So that is my major suggestion, that among all these things that we have to do, that we do pay some attention to the relevance of evidence-based interventions for the Native American communities that need to be served.

Thank you.

[The prepared statement of Ms. LaFromboise follows:]

PREPARED STATEMENT OF TERESA D. LAFROMBOISE, PH.D., ASSOCIATE PROFESSOR OF COUNSELING PSYCHOLOGY AND CHAIR OF NATIVE AMERICAN STUDIES, STANFORD UNIVERSITY

Good morning, Honorable Chairman Dorgan and Vice-Chairman Barrasso and Honorable Members of the Committee. Thank you for your invitation to personally testify before this Committee and to present my views concerning progress made in the area of preventing American Indian and Alaska Native (AI/AN) youth suicidal behavior.

I come before you as a professor of Counseling Psychology, a mother of an enrolled member of the Turtle Mountain Band of Chippewa, the developer and evaluator of a suicide prevention program entitled the *American Indian Life Skills,* a researcher of ethnic identity and mental health, and a former elementary and secondary teacher in urban and reservation schools. I hope that my testimony will assist the Com-

mittee in taking stock of the potential for evidence-based school and community interventions to prevent AI/AN youth suicide and promote positive AI/AN mental health.

In the 21st Century, suicide continues to be a vivid manifestation of distress among Native people. Untimely death accounts for almost one in five deaths among AI/AN youth 15–19 years of age. This proportion is considerably higher than that of youth from other ethnic groups or the general population (Centers for Disease Control, 2006). Completed suicide is 72 percent more common among AI/AN people than the general population (Indian Health Service, 2001). The estimated rate of completed suicides among AI/AN youth ages 5–14 years is 2.1 per 100,000, compared to 0.8 per 100,000 for all U.S. youth in the same age group; the rate of completed suicides among AI/AN youth ages 15–24 years is 37.4 per 100,000, compared to 11.4 per 100,000 for all U.S. youth in the same age group (Indian Health Service, 2002).

In recent years federal efforts such as the Surgeon General's Call to Action and the National Strategy for Suicide Prevention (U.S. Department of Health and Human Services, 1999, 2001) have reflected growing concern over youth suicide within the U.S. Hearings on Indian youth suicide sponsored by this Committee have provided a forum for citizens to advocate for greater attention and services for those AI/AN youth who elect not to seek help for suicidal ideation due to stigma or embarrassment, who seem to lack regard for the deadly consequences of their behavior, and whose suicidal intent goes unrecognized, unappreciated, and untreated.

Funds appropriated by the Garrett Lee Smith Memorial Act have served as a catalyst for the mobilization of suicide prevention programs in many AI/AN communities at highest risk for suicide. I have been fortunate to work with three SAMHSA funded programs for AI/AN youth suicide prevention . I designed a Training of Trainers program with staff from Native Aspirations (JoAnn Kauffman, PI) to train community members from 30 reservations in regional training in Wolf Point, MT, Rosebud, SD, Pine Ridge, SD, and Anchorage, AK. I was also supported by the Indian Country Child Trauma Center (Dee BigFoot, PI) to develop and field test a middle school version of the *American Indian Life Skills* on the Omaha reservation. As a consultant to the Helping Hands Project of the Puyallup tribe (Danelle Reed Inderbitzen, PI), I worked with mental health workers from the tribal health authority who worked in tandem with 6th grade teachers at their tribal school to field test the middle school version of *AILS*. Through these experiences I worked with some incredible AI/AN interventionists and witnessed directly the power of traditional healing in conjunction with effective conventional psychological practices. However, I also observed the frustration of tribal leaders at the slowness with which these programs have reached AI/AN communities.

As a psychologist, I realize that the psychological risk for suicidality includes comorbidity with psychiatric and substance use disorders. However, as a counseling psychologist who studies learning and adaptation, I believe that decisions related to suicidal behavior among the majority of AI/AN youth may be attributed to direct learning or modeling influences (e.g., family, peer, extended family suicide attempts/deaths by suicide) in conjunction with certain contextual sources (e.g., perceived discrimination, historical trauma, acculturation stress) and individual characteristics (e.g., depression, PTSD). I also believe that many risk factors for suicide are similar to risk factors for other problematic behaviors such as alcohol and drug abuse or engaging in unsafe sex. When cast from this more social cognitive perspective, suicide and other forms of risk behavior are more likely to be preventable.

Suicide Prevention and Treatment for AI/AN Youth

"The goal of most prevention programs is to assist an individual in fulfilling their normative and developmentally appropriate potential including a positive sense of self-esteem, mastery, well-being, and social inclusion and to strengthen their ability to cope with adversity" (National Research Council and Institute of Medicine, 2009, p. 74). Five programs, targeting AI/AN youth suicide, have been featured in noted reviews of suicide prevention (National Academy of Sciences, 2002; Goldston, Molock, Whitbeck, Murakami, Zayas, & Hall, 2008). These include: *The Zuni Life Skills Development Curriculum* (LaFromboise & Howard-Pitney, 1994), *the Wind River Behavioral Program* (Tower, 1989), the *Tohono O'odham Psychology Service* (Kahn, Lejero, Antone, Francisco, & Manuel, 1988), the *Western Athabaskan Natural Helpers Program* (May, Serna, Hurt, & DeBruyn, 2005), and the *Indian Suicide Prevention Center* (Shore, Bopp, Waller, & Dawes, 1972). These prevention programs incorporate positive messages regarding cultural heritage that increase self-esteem and sense of mastery among AI/AN adolescents and focus on protective factors in a culturally appropriate context. They provide strong grounding for adolescent prosocial behaviors through close ties with extended family involvement and resilient

elders. They also integrate tribal leaders in the prevention effort and encourage youth to use traditional ways of seeking social support (May, et al., 2005).

These programs privilege AI/AN ways of knowing, behavioral expectations, attitudes and values and encourage youth to be embedded in cultural practices. For the most part, suicide prevention programs that incorporate cultural teachings and traditions into the psychological intervention have been well-received by AI/AN communities and some are found to have promising outcomes. Research has shown that enculturation is positively related to protective factors such as academic success and pro-social behaviors (Whitbeck, Hoyt, Stubben, & LaFromboise, 2001) and negatively related to depression (LaFromboise, Albright, & Harris, forthcoming). One of the complexities in implementing these interventions across tribal groups is the extent of major cultural differences between more than 560 different tribes. However, researchers who struggle with the problem of lack of generalizability of prevention programs are exploring efforts to identify common elements among tribes with closely related traditions that could be incorporated into prevention programs on a wide scale basis (See Mohatt et al., 2004; Allen et al., 2006).

Prevention Intervention in AI/AN Communities

Within mainstream society and a few select cultural groups there has been considerable evidence for the positive effects of family, school, and community prevention interventions to increase the resilience of youth and reduce their risk for mental, emotional, and behavioral disorders. A recent report just released by the National Academy of Sciences (2009), entitled *Preventing Mental, Emotional and Behavioral Disorders among Young People,* highlights interventions designed to prevent many of the common correlates of suicidal ideation (e.g., depression, substance abuse, interpersonal conflict, constricted thinking). The recommended interventions also focus on strengthening families, improving social relationships, and reducing aggressive behavior and school-based violence. I believe that some of the prevention programs featured in this report could provide a mechanism for advancing suicide prevention efforts in Indian Country.

I cannot give this testimony without also advocating for the expansion of social emotional learning in AI/AN schools. I realize that schools are often overloaded with other academic-related priorities. However, social emotional development programs in schools have been found to have a positive impact on academic outcomes, especially among elementary school-age children. Research by Durlak and colleagues (2007) indicated that the effects of social and emotional learning programs were equivalent to a 10 percent point gain in test performance. Students who also participated in this intervention research demonstrated improvements in school engagement and grades.

Unfortunately, few of the interventions showcased in the National Academy report have been implemented in Indian Country. Evidence has been found for long-term results of a few of the interventions with African American and Latino-Latina youth. No doubt that given the unique historical context of AI/AN communities, there is resistance to the mere transposing of evidence based interventions onto prevention programs with AI/AN youth. It is essential for AI/AN researchers to assess whether the relevant recommended prevention interventions featured in this report are generic enough to be found effective with AI/AN youth. Furthermore, AI/AN researchers should work to culturally adapt evidence based interventions while maintaining the critical core content and dosage of the intervention.

Recommendations

1. Allocate federal funds for a technical assistance center to provide training in the implementation and evaluation of evidence based prevention interventions in Indian Country. This center could assist in improving the cultural competence of service providers in terms of knowledge of the relevant risk and protective factors for suicide among AI/AN youth. This center would encourage the expansion of AI/AN community-based research collaborations.

2. Expand social emotional development activities in AI/AN schools throughout the course of Kindergarten through 12th grade.

3. Increase the number of AI/ANs in the fields of psychology, social work, public health, medicine, and education to further advancement of prevention efforts in Indian country.

References will be provided upon request.

The CHAIRMAN. Thank you very much.

I am going to call on my colleagues. I will ask questions at the end. I did want to mention that Dana Lee Jetty is accompanied by

her parents, who are in the room: James Dean Jetty, right there, Mr. Jetty, thank you; and Cora Whiteman Tiger. Thank you for being with us, both of you. We appreciate your being here.

Senator Murkowski?

STATEMENT OF HON. LISA MURKOWSKI,
U.S. SENATOR FROM ALASKA

Senator MURKOWSKI. Thank you, Mr. Chairman. And thank you for convening this hearing.

To those of you who have given testimony this morning, thank you very much. Ms. Jetty, thank you. Your testimony is very heartfelt and so very important to be able to be an advocate in an area that is, as the Chairman has mentioned, very personally challenging, and the emotional side that you bring to this issue is heard, and certainly very heartfelt.

I appreciate what you have just given us, Ms. LaFromboise and Mr. Moore, in terms of the need to tailor the programs so that we do have the cultural sensitivities, if you will, that we have programs that are not kind of a one size fits all. If it works in Akron, Ohio, it is going to work in Alakanuk. Well, we know that is not the situation. What we need is the flexibility within the funding that comes available to us in our communities, whether it is villages in Alaska or out on the Rosebud Reservation, to craft that so that it works for the population that we are dealing with.

We have been the recipient up in the Northwest Arctic Borough. Amenliak has been the recipient of a Garret Lee Smith grant that has allowed them to really tailor what they are doing to adopt a more holistic approach that really follows the Inupiak values. That is going to be important to the success of the efforts that we do up there.

Mr. Walker, I have just a technical question for you on your recommendation for a standing committee. I want to ask the question because I was just in Juneau last week with Dr. Broderick. SAMHSA was awarding a grant to the community of Juneau. We heard from a gentleman who had lost his son to suicide, a 16 year old boy. This was some 10 years or so ago. In that community, at the time, the stigma on suicide and talking about it, similar to what the Majority Leader spoke to.

They wouldn't talk about it in the schools, so there was no reach-out in the schools to the other students. The community was afraid to talk about it. It was this scar, that somehow or other our community was not as good as it was because of this unexpected, absolutely out of the blue suicide of an "ordinary young teenage boy."

Do we still have that resistance in the schools to talk about it? I have had, coming out of my boy's elementary school, I have had parents that have suggested to me that we don't want to have our young kids exposed to these ideas or even knowing that suicide is out there, because then they might think about it. To me, I am one who is really focused on prevention.

But how much of a stigma, how much difficulty do we have in getting out to not the kids in high school, but the kids in elementary school, this level of awareness and, you know, talk to one another so that you, Dana, would have known what your sister was

going through. What is the attitude out there right now? Mr. Walker?

Dr. WALKER. You bring up a very important point, because there is the stigma connected to, if you will, the feeling of failure and somehow you have let your community down and you don't want to talk about it. But there is also, it comes so often, the numbing process that I mentioned, that you really want to make it go away. That is kind of a natural phenomena that happens inside all of us, in the pain and intensity. That is why I think it is a disaster, that people become so numb to the process they really don't want to respond.

If I could give an example. I visited a community, a tribe, that had a suicide cluster. It was very difficult for me to even document how many people had died. The data, you know, aren't collected. I went to the coroner system. I went to the medical folks. I went to the State medical examiner trying to collect the data.

I came to realize that people were, indeed, that encouragement not to reveal or not to open that up is systematic. I believe, too, that first of all, it doesn't allow us to understand the problem. It certainly doesn't allow a community to work through the grieving process when the information is not shared.

Now, you ask a tough question. The question has to do with at what age do we somehow allow these things to happen. There might be families here who have different views about this, but I think that it needs to be open. Facts are facts in communities, and everybody knows when people pass away, and everybody deals with that in their own way. I can't help but think that we need to have an openness process to make that workable and work through.

Having said that, what do you do when the people who are documenting the suicide are relatives of the person, so they are in authority to document, but they also are relatives. That puts them in a very, you have to be a clinician and you have to be a family member at the same time. That is very difficult. That is why the workload and the workforce in Indian Country needs to be thought through in a much more deliberate way. There are not enough people there, and there is not enough training. To be able to do what you are wanting to do would require, wouldn't it be nice if somebody at that school had the ability to work with family, but when they were involved with the family, that someone else could back them up. We have no policies like that anywhere in Indian Country.

Senator MURKOWSKI. You wanted to join in this?

Ms. LAFROMBOISE. Yes, I did, because I wanted to just mention from a prevention perspective, with the work that we have done with Zuni Life Skills, American Indian Life Skills, it is universal intervention in that all students go through this curriculum, rather than just at-risk youth.

Senator MURKOWSKI. And regardless of age?

Ms. LAFROMBOISE. Well, it has been developed for high school students. I wanted to answer this question about age as well. One of the points of it is that we know that youth talk to their friends, more likely than some of the adults, and we want them to be able to get their friends to help. We have found that, part of the goal

is to reduce the stigma by allowing people to have someone that they can talk to about this.

Now, with the middle school students, people ask about age. We have gone into communities where people say, well, we don't really know how active students are in terms of suicide at the middle school level, but we want to find out. In one of the schools, and it is in some of the documentation that I have presented, the middle school students, 19.7 percent of them had already attempted. Of those, middle school students on a reservation in the Northern Plains, 10 percent had attempted more than once.

When we do this, we actually have a series of questions that we ask, and make clear that we are not talking about just thinking about it, but have you done something physical to yourself to end your life. We ask, would you mind telling us what was going on at that time, with just some lines for open-ended comments. And the students will tell us. They will write it on a sheet of paper.

Now, what I have heard in focus groups in some of the communities, students will talk among themselves. In that particular study, 97 percent of students had not sought help because if they seek help, then that means that they might be moved to a psychiatric hospital hundreds of miles away because in-patient help isn't there as much as it needs to be locally. Or there might even be one bed assigned at the hospital and the charge nurse at that particular time doesn't want to deal with it and doesn't want the person admitted so they go to the jail instead of the hospital. So you know how that goes, just to add.

Senator MURKOWSKI. Mr. Chairman, thank you very much.

Thank you.

The CHAIRMAN. Senator Udall?

STATEMENT OF HON. TOM UDALL,
U.S. SENATOR FROM NEW MEXICO

Senator UDALL. Thank you very much, Mr. Chairman, and thanks for your leadership on this issue. I think you and your staff have pulled together a distinguished panel and some very, very moving testimony here today.

I was impacted a lot by Senator Reid and his testimony earlier, where he talked about my cousin, Gordon Smith, and what happened with Gordon's family. I wish Senator Reid was here for me to just thank him for what he did for my family and thank him for the support when the family was really in crisis.

Dana Lee, you have helped us by coming forward and talking about your sister. It is a horrible feeling and you conveyed to us what you have gone through and what the family has gone through. But by stepping forward, I think you educate all of us and allow us to focus on what the issue is and what we can do about it. So thank you very much for being here today.

As I listen to this panel, I hear you talking about some very simple things in order to deal with this. I mean, one of them is just for a young person to be able to have somebody to talk to about their problems, about their feelings, what they are going through. Hayes, you mentioned just changing the way schools approach this in terms of protocols, taking institutions that are there and making

those institutions reform themselves so that they deal specifically with the issue of youth suicide in Indian Country.

So the question I want to ask, I guess to Teresa and Hayes to start with, but happy to have any of the others jump in is, how much of this is about resources and how much of this is about realigning the use of current resources? And I think Teresa you talked about the Garret Lee Smith funds and utilizing those funds. Is it about resources? Or is it about taking what is in place and making sure that the people that are either in schools or other institutions that, tribal leaders, tribal healers, that they are doing the kinds of things that you are talking about?

Please, Hayes, go ahead.

Mr. LEWIS. Mr. Chair, Senator Udall, in many cases it is realigning resources that are present within the tribal communities, including the schools. A lot of our school organizations are not set up to respond to the variety of tribal community issues and really have not made schools a safe place for all children.

By that, if you look at, and I was just in a school district last week. This is a high school. Kids are coming out of the classrooms, walking around. Other kids are coming out during class, walking around. Maybe they went to the rest room or something, or that is what they told the teacher, but they are harassing each other in the hallways, text-messaging each other negative notes and things like that. So there is a lot of that kind of bullying going on right under the noses of the school administration and the staff.

That is not to say that they are not trying their best, but at the same time, I think school resources are sometimes stressed. But at the same time, you can look within a community and see what other tribal resources are available, so that you can start addressing prevention, strengthening children, providing those kinds of skills that will give them more than just one option.

Just in a quick response to your question, Madam. In a tribal community many times we are told you can't talk about death because you are going to bring on more death. The dilemma we had was that if we don't talk about death and dying, how are we going to help the living? And so, it is a circular kind of a situation that you are involved in.

So we decided we will talk about death and dying, but it is really a determinant of how you talk about death and dying, and how you are respectful to younger children. You talk about death and dying, or you talk about options like strengths, the cultural strengths that you have, the cultural taboos against taking your own life, because I think all of the tribes have that. You are not to take your own life for a number of reasons, and they vary from tribe to tribe. But at the same time, if you talk about the strengths of ancestors and the strength of character and values that we have, then you can lead into other areas of discussion about death and dying.

But I believe on the resource issue, there still needs to be a lot of work in that area. In New Mexico, I know there is a specific account out of the Public Law 81–874 impact aid that 25 percent of it is earmarked for the use for Indian children for cultural, emotional and academic strengthening of Indian children. That means programming of different kinds, and many of our school districts carry that amount across to the next year, without really investing

in programs that will strengthen and create safe places for all children.

Ms. LAFROMBOISE. I would suggest that we need more resources. Part of the work that we have done, it seems to me, is just the tip of the iceberg in terms of what could be done in training people and working with communities to implement prevention work. You know, prevention is part of the mission statement, of IHS, but we know that there isn't much allocated for that activity, if at all. When we train people, we raise consciousness. People then try to go back into their communities to implement the intervention. They are sort of like the champions of this intervention, but there are no resources for it, or very little.

In some of the training programs we have done, we have actually had people where, after a couple of days, I realized that almost everyone at the table doesn't have a job. Or we might serve lunch, and people literally leave and take what they have been given for lunch home and then come back to the training immediately. So I mean, there is such poverty and such pervasive hardship that there needs to be more resources in terms of mental health support and support of social-emotional development in schools.

The other thing with the work in terms of restrictions, is the fear in terms of No Child Left Behind of having much in terms of social-emotional development or mental health programming in the schools because it might negatively impact test scores. We do now have research that says that there can be as much as a 10 point difference in terms of standardized test scores among students that have received this kind of work, this kind of training, and more involvement in school.

So I think that it takes actually educating teachers for them to actually be willing to do some of this work in their classrooms. And it also takes, some technical assistance for those people who are para-professionals and community members who can do so much in terms of this kind of work.

Mr. MOORE. If I could also offer an answer. At Rosebud, the Administration for Native Americans out of HHS, and their immediate response to our rising and escalating suicide statistics there, provided resources for us to create some youth activities this last summer. We trained 150 kids, mostly young teenagers, young adults, in the community emergency response team, CERT, training that is offered by FEMA. It gave them some essential skills, emergency medical response, fire suppression, et cetera. It trains lay people to be the immediate first responders in the event of an incident, before the professional first responders get there. They had this shared collective experience.

One of the young men who graduated from that program, that training, ended up protecting a car accident victim from going into shock until the first responders got there, by his training there. There were three young girls who were just a day away from completing their training and getting their certificate. They were spending the night together.

One of the girls got up and left, and had been gone for some time. The other two girls went to look for her and they found her hanging in a closet. With the skills they had just learned, they revived her. They got her down in time and they revived her and re-

suscitated her. So now they have this energy to become doctors and nurses themselves, and want to respond to that in a very positive way.

But the resource issue is that now we are without the money to keep this collective group of young people together in some way to have ongoing work with them, ongoing development with them. So the hot shot response provided a base for them, but we simply don't have the resources to keep the collective going, and for these kids to continue in activities together, which has been one of the strengths of that program during that summer.

Dr. WALKER. I would like to respond as well. We do need more sources, simply stated. I don't want to under-sell that issue, but I want to go back to why we are having this meeting today. The core question is, what has happened in the last two to three years. I think we need to take a serious look at what has happened at Standing Rock. It is one of the best examples.

They received an emergency grant from SAMHSA. They received two or three other resources. What I would tell you in a document that I received from them is that they have more mental health services readily available across their reservation. The suicide rate has gone down. They have more people working within the school system and much more discussion consequently within the community about these issues.

So a little bit of money made a difference. I think we would all want to say that this is a hopeless thing, because that feeds right in with the issue. We know that when resources get directed, even though they might be small, Native Aspirations does not put huge amounts of money into communities, but they help mobilize and work in the community. Those systems work.

Indian Health is under-funded. I would say 40 percent under-funded. I have felt that way for the last 20 years. I think that we need to really deal with the issues.

Now, a point of hope has to do with what can we do, if we go out and train these people. Remember the grants only last three years. I would like to see them increase to five years, number one. I would also like to see some kind of integration of grants into continued health care. That would be an important step.

We can also take a look at tele-health, tele-medicine work to maintain training and certification of our counselors and health care providers across Indian Country. One of the problems we have is in isolated remote areas. Counselors get their training and certification, but they can't maintain it over time because they can't receive supervision in their immediate area.

Now, what that means is they can't bill for Medicare and Medicaid services. So there are ways that we can actually take smaller steps in regards to how we educate and maintain the training of our people in the communities.

The CHAIRMAN. Mr. Walker, the point you made that I think is important is we have full-scale health care rationing on Indian reservations. It ought to be headline news in newspapers because it is a scandal. Do you think if there were health care rationing among U.S. Senators it wouldn't be fixed in a minute? Health care rationing is something that is almost unbelievable and it goes on

every single day with the most vulnerable population in this Country, and it is shameful.

And you are right about the 40 percent. Forty percent of the health care needs of American Indians are unmet. Now, the President's budget was just released today. It asks $4 billion for the Indian Health Service. That is approximately $600 million more than fiscal year 2008. That is a good sign, a very good sign. We need to meet our obligations. We ought to go read the treaties. We ought to go re-read the treaties, that the United States Government signed with Indians.

I don't know if you used the term rationing, but it is a shameful thing that ought to be headline news across this Country.

Now, I want to ask, and I had invited my colleagues to inquire first. We have also been joined by Senator Johanns. What I would like to do is ask a couple of questions. I will recognize the Senator from Nebraska if he has inquiries. Then we are going to go to our colleagues who have been very, very patient this morning. My thanks to them, Mr. McSwain and Dr. Broderick.

Dana Lee Jetty, I told you I am sure none of us understand how difficult it is to come some months after losing your younger sister and talk about it publicly. You are going to school in Minnewaukan, North Dakota, is that right?

Ms. JETTY. Yes.

The CHAIRMAN. What year are you in school?

Ms. JETTY. I am a sophomore.

The CHAIRMAN. I have been to the Spirit Lake Nation many times. In fact, I have been there to have meetings about teen suicide because there have been other teen suicides there. In your testimony, you indicated that you knew that your mom had concerns about your sister before her suicide, and you say your mom did all the right things. She took her to the doctor, talked to counselors, and even had her evaluated by mental health professionals from Indian Health Service. They dismissed your mom's concerns and diagnosed your sister as being a typical teenager.

Ms. JETTY. Yes.

The CHAIRMAN. So your sister had some issues. Your mother recognized that, and went to seek out some assistance.

Ms. JETTY. Yes.

The CHAIRMAN. And the tragedy at the end of this is your sister took her life.

As a young Indian teen, are you familiar with others who have performed, as the professionals call it, ideation, talking about perhaps ending their life, or those who have actually made an attempt to end their life?

Ms. JETTY. Yes. I know some people have actually come up to me and asked me, you know, what should I do? And how can I help myself? So what me and my family have been doing, we have actually been going around to different places, to schools, to jails, where teenagers are, and we tell them that there is help that they can get out there. Some counselors, like you said, they just push aside the person's feelings, you know, how they want to, the help that they want to get. And I don't know.

The CHAIRMAN. Dana Lee, I told you that I met with a group of Indian teenagers at Standing Rock. Just me and a group of them,

no other adults present. I just asked them about their lives. What is going on in their lives? What do you think? I talked to them about the cluster of suicides, asked them to give me their impressions of their classmates and so on. It was a fascinating discussion, and in many ways, also troubling and in some ways hopeful.

But one of the things that some of those students told me was that their acquaintances that had committed suicide, and some who had tried it, felt that perhaps it wasn't a desire to be dead, or to actually end up being dead as a result of this. It was a desire to cry out for help, but without thinking this is forever, this is final, this is death. Do you sense that among the young people that talk to you about these issues?

Ms. JETTY. Yes, actually I do. Yes. Some of them, they think that it is the only way that they can feel better, that they won't feel the pain that they are feeling. It is really, I don't know. It is a big concern.

The CHAIRMAN. And there is, as all of the professionals on the panel have described to us appropriately, not one reason for suicide. You know, there just isn't one reason you can say, here is what is triggering it. It is a series of emotional things that, I think in my own view, relates to circumstances of life and feelings that one doesn't have the same opportunities and things are tough, and you know, poverty and a whole range of things. Substance abuse can play a role sometimes.

So it is tragic when anyone commits suicide. The person that I found who had committed suicide was an adult, only 40 years old. But to have someone 14 years old take their life is, as you know, such a tragedy.

So again, let me just thank you for being here. But when you tell me that you go to jails and schools, you and your family, and are doing something in your sister's name, I think your younger sister would be mighty proud of her older sister, and we appreciate your doing it.

To those of you who have put on the public record here your experience and your work, I have a number of questions, but I think I am going to send you these questions. I am going to ask more specifically about some of the services and, Mr. Walker, how you are going to disseminate the guide throughout Indian Country on what your plans are.

And Mr. Hayes, I will ask you to respond about when the suicide prevention program ceased in your community, when did you see repercussions of that. I have a number of questions, but I think what I would like to do is submit them to you and ask if you could respond for the Committee record in writing so that I might get the testimony of Mr. McSwain and Dr. Broderick.

The reason I wanted them to stay was to hear something very valuable from your testimony, especially you professionals. It is very important for Indian Health Service and SAMHSA to understand what it is you say and what it is you do out in Indian Country across America.

So let me call on my colleague from Nebraska for any comments or questions you might have.

STATEMENT OF HON. MIKE JOHANNS,
U.S. SENATOR FROM NEBRASKA

Senator JOHANNS. Well, let me start out and thank the Chairman for holding this hearing, a very, very important topic.

Dana Lee, if I could just inquire. Thinking about your friends and the very sad case of your sister committing suicide, do you think there is sometimes a reluctance with kids to reach out and seek help from, I don't know who, a parent, a counselor, a teacher? Would that be kind of a stigma? Would other kids look down on them? Is that a problem? And if you see that as a problem, could you give us any advice on how we might think about how to help that situation?

Ms. JETTY. Yes, I think they do look down on them. They see that other kids are doing it, and they think that is the only way they know how to deal with them. They really need to talk to somebody who knows what they are going through and who can really relate to them and know how to help them. And sometimes, kids, they go, they talk to counselors, but it is not the stuff they want to hear. So I think, you know, we can really get to them by talking to trained professionals who know what to do and stuff, so.

Senator JOHANNS. I appreciate your honesty in answering that. I wonder if it would be helpful to think about an approach where certainly a trained professional would be involved, but there would also be your own peers involved. You know, sometimes you will share things with a friend that you would, my daughter or my son, would never tell me, but they really need somebody to talk about it. What would you think about that kind of idea? Do you think that would help?

Ms. JETTY. Yes, I think that would really help, I think, you know, like other students. Yes.

Senator JOHANNS. Okay. I really appreciate you being here. I think it is very, very helpful to us as we think about how to fashion an approach to maybe prevent this from happening in another family. Thank you.

Ms. JETTY. Thank you.

The CHAIRMAN. I am going to dismiss the panel, but as I do, let me again thank Dana Lee's parents, James Dean Jetty and Cora Whiteman Tiger. Thank you for accompanying your daughter today and making it possible for her to testify.

And I want to thank especially those of you who have testified about your programs and the professional work that is being done. Dr. LaFromboise, we particularly appreciate your lineage from Turtle Mountain and appreciate your work at Stanford.

Ms. LAFROMBOISE. Thank you.

The CHAIRMAN. And let me thank you for being here. All of you are welcome to stay and listen to our next two witnesses from the Indian Health Service and from SAMHSA. Thank you very much.

Now, Mr. McSwain and Dr. Broderick, I thank both of you for being so patient with us. This took a while, but I think it would be enormously helpful for you to hear, so we appreciate your being here.

Director McSwain, thank you very much. You may proceed, after which we will hear from Dr. Eric Broderick.

STATEMENT OF HON. ROBERT G. MCSWAIN, DIRECTOR, INDIAN HEALTH SERVICE, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. MCSWAIN. Thank you, Mr. Chairman and members of the Committee. I, too, enjoyed to a great degree, because I learned a lot from the previous panel. I made copious notes, and certainly had a chance to talk with Dana and her experience, so that it was helpful to understand our system and how our system interfaces, the clinical system.

You certainly have my statement. I am accompanied today by Dr. Richard Olson, Director of the Office of Clinical and Preventive Services, and Dr. Rose Weahkee, Public Health Adviser, Division of Behavioral Health. And certainly I appreciate the opportunity today to testify on youth suicide in Indian Country, recognizing that my predecessors appeared before you and this Committee before in several parts of the Country.

As was mentioned, I think it is an important feature of this hearing is that suicides and suicide-related behaviors do exact a profound toll on American Indian and Alaska Native communities. As it was mentioned, suicides just reverberate through communities, small or large, and affect the survivors many years after the actual incident.

I won't go through the, you have certainly the data, and I just want to say that we confirm the data of the suicide rates that were shared with you earlier. The one thing that tends to make the numbers a little different when you are talking to a large organization like SAMHSA or U.S. national numbers is that remember our focus is on 1.9 million Indian people living in 35 States on or near a reservation. So our numbers are a little bit smaller in terms of the actual prevalence and the like. So that understood, there will be some differences in the final numbers.

You know, suicide is a very complicated public health challenge. As we talked about it earlier today, certainly there are a whole lot of factors, and as you said, Mr. Chairman, any one factor. And clearly, the only pursuit of a multi-targeted coordinated and persistent effort is acutely aware of the cultural context. All those issues were shared today.

The total cultural context of suicide blends the best of traditional American Indian and Alaska Native healing wisdom and Western public health tools, and is likely to succeed not only on a community basis, but also on a national basis.

Since this hearing is a follow-up, I would like to simply highlight some activities that have been occurring since the previous two hearings. First is in the area of collaboration. I know that there was concern about the Indian Health Service collaborating and partnering with the Bureau of Indian Affairs and what they have going. Clearly, we have had a number of discussions, and I can assure you that I had discussions with the Bureau of Indian Affairs this last year until their leadership changed a bit. But basically, we are still continuing to focus.

I think the important is that while there may be a sort of lack of real coordination at a national level, I can say that there is a lot of activity going on out in the field in the service units, in the communities, with the Bureau of Indian Affairs. I think a case in

point is that IHS continues to provide both medical and behavioral health-related services to BIA-funded youth detention centers. For example, the Chinle Navajo Nation Youth Detention Center in Arizona was allocated both a nurse practitioner and regular contacts from the local IHS alcohol and substance abuse coordinator. That is just one example of many across the Country. If I don't run out of time today in my opening, I will talk about some other things that are going on in other States.

But IHS is fully involved since the last time in a number of things. We are involved in many statewide suicide prevention teams, coalitions. There are two Alaska Natives who were appointed to the Alaska statewide Suicide Prevention Council. One is also a member of the Suicide Prevention Committee, which is the IHS prevention committee. An IHS representative sits on the Arizona State Suicide Prevention Coalition. The Oklahoma area also cosponsored a suicide prevention conference with the State of Oklahoma in December.

There are a lot of things happening nationally. My colleague to my left here, we are working very closely with SAMHSA, the CDC, NIMH, and the like. Suicide prevention programming was offered at the annual IHS-SAMHSA meeting last summer, and we are looking forward to another session with SAMHSA as we move forward, where there were between 400 and 600 people who were actually at the conference.

We have been working nationally with NCAI and other national Indian organizations. NCAI has established its Suicide Prevention Work Group. The Suicide Prevention Resource Center works collaboratively with Indian Health Service.

On an international level, the department has a memorandum of understanding with the country of Canada and our counterpart, First Nations. We are working together for those common issues. What are they experiencing up there in Canada as well? And two learning exchange meetings have occurred and are scheduled to continue.

I just want to mention to you that I know there will be a question about the $14 million that the Indian Health Service was appropriated. It was a deliberate process on my part to establish a national Tribal Advisory Committee where you heard today, the importance of tribal communities being engaged. I wanted tribal leaders to be engaged in how best to target the resources that were given. They have come forward with a series of recommendations, and I am prepared to deliver on those recommendations very soon. We are looking at upwards of 60 grants in the committee to begin to address suicide and methamphetamine abuse. Then, of course, that was the first charge I gave to the new group as they convened, and said, look, I want your ideas on best how to target these limited resources.

Let me close with just a few examples of IHS area-specific suicide prevention activities. The Aberdeen area has established a suicide prevention strategic plan. Again, at least it is on the table and they are working through it. They have also used the question-persuade-refer training for every reservation, which is actually referred to as a QPR. And of course, in the Alaska area, the big news in Alaska is the behavioral health aids that are being actually

trained and deployed throughout the villages in Alaska. Another event certainly to address local needs, to go along with the others, are community health aids, and certainly the dental health aid therapists that occur in Alaska.

Bemidji began their efforts with applied suicide intervention skills training, QPR, the North Dakota Project and American Indian Life Skills training, and they continue to work throughout the area. There are certainly a number of activities going on in the Billings area, which includes Wyoming. I am sorry that Senator Barrasso isn't here, but we have a number of activities going on in both Montana and Wyoming, and of course working again with SAMHSA, you will hear more from Dr. Broderick on some activities there.

The Phoenix area has teamed up with the State of Nevada for those interested in providing training to reservations in Utah, Nevada and Arizona. The Portland area, in partnership with the Northwest Portland Area Indian Health board, has developed an area-wide suicide prevention plan. And the Navajo Nation has a strategic plan, a suicide prevention team, and is working with the tribe with suicide prevention activities. In fact, they actually have a special project that is referred to as Suicide: Breaking the Silence, and we have all heard about that today.

Let me just simply say that our successes to date, and that is whether it has been Colville or Flathead, has been community-based. I mean, we have gotten into the community and the community has actually taken up ownership. I think our successes will continue where American Indian and Alaska Native communities take ownership and lead the effort, and then we are helping and supporting them as they move forward.

Mr. Chairman, this concludes my summary statement. Thank you for this opportunity to discuss youth suicide in Indian Country, and I will be happy to answer of your questions.

[The prepared statement of Mr. McSwain follows:]

PREPARED STATEMENT OF HON. ROBERT G. MCSWAIN, DIRECTOR, INDIAN HEALTH SERVICE, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. Chairman and Members of the Committee:

Good morning, I am Robert McSwain, Director of the Indian Health Service (IHS). I am accompanied by Richard Olson, M.D., Acting Director, Office of Clinical and Preventive Services, and Rose Weahkee, Ph.D., Public Health Advisor, Division of Behavioral Health. Today, I appreciate the opportunity to testify on youth suicide in Indian Country.

The IHS has the responsibility for the delivery of health services to an estimated 1.9 million Federally-recognized American Indians and Alaska Natives (AI/AN) through a system of IHS, Tribal, and urban (I/T/U) operated facilities and programs based on treaties, judicial decisions, and statutes. The mission of the agency is to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level, in partnership with the population we serve. The agency goal is to assure that comprehensive, culturally acceptable personal and public health services are available and accessible to the service population. Our duty is to uphold the Federal government's obligation to promote healthy American Indian and Alaska Native people, communities, and cultures and to honor and protect the inherent sovereign rights of Tribes.

Two major pieces of legislation are at the core of the Federal government's responsibility for meeting the health needs of American Indians/Alaska Natives: The Snyder Act of 1921, P.L. 67–85, and the Indian Health Care Improvement Act (IHCIA), P.L. 94–437, as amended. The Snyder Act authorized regular appropriations for "the relief of distress and conservation of health" of American Indians/Alaska Natives.

The IHCIA was enacted "to implement the Federal responsibility for the care and education of the Indian people by improving the services and facilities of Federal Indian health programs and encouraging maximum participation of Indians in such programs." Like the Snyder Act, the IHCIA provides the authority for the provision of programs, services, and activities to address the health needs of American Indians and Alaska Natives. The IHCIA also included authorities for the recruitment and retention of health professionals serving Indian communities, health services for people, and the construction, replacement, and repair of healthcare facilities.

The Department of Health and Human Services (HHS) has been proactive in raising the awareness of Tribal issues through the process of Tribal consultation. As such, HHS recognizes the authority provided in the Native American Programs Act of 1974, and utilizes the Intradepartmental Council for Native American Affairs to address cross cutting issues such as suicide and to seek opportunities for collaboration and coordination among HHS programs serving Native Americans.

We are here today to discuss youth suicide in Indian Country.

Background

Suicides and suicide-related behaviors exact a profound toll on American Indian and Alaska Native communities. Suicides reverberate through close-knit communities and continue to affect survivors many years after the actual incident.

- Using the latest information available, the American Indian and Alaska Native suicide rate (17.9) for the three year period (2002–2004) in the IHS service areas is 1.7 times that of U.S. all races rate (10.8) for 2003. (This information will be published in the upcoming "Trends in Indian Health, 2002–2003").
- Suicide is the second leading cause of death behind unintentional injuries for Indian youth ages 15–24 residing in IHS service areas and is 3.5 times higher than the national average. (This information will be published in the upcoming "Trends in Indian Health, 2002–2003").
- Suicide is the 6th leading cause of death overall for males residing in IHS service areas and ranks ahead of homicide. (This information will be published in the upcoming "Trends in Indian Health, 2002–2003").
- American Indian and Alaska Native young people ages 15–34 make up 64 percent of all suicides in Indian country. (This information will be published in the upcoming "Trends in Indian Health, 2002–2003").

On a national level, many American Indian and Alaska Native communities are affected by very high levels of suicide, poverty, unemployment, accidental death, domestic violence, alcoholism, and child neglect.[1] According to the Institute of Medicine, an estimated 90 percent of individuals who die by suicide have a mental illness, a substance abuse disorder, or both.[2] According to a 2001 mental health supplement report of the Surgeon General, "Mental Health: Culture, Race, and Ethnicity", there are limited mental health services in Tribal and urban Indian communities.[3] While the need for mental health care is great; services are lacking, and access can be difficult and costly.[4]

The system of services for treating mental health problems is a complex and often fragmented system of tribal, federal, state, local, and community-based services. The availability and adequacy of mental health programs varies considerably across communities.[5] American Indian youth are more likely than non-Indian children to receive treatment through the juvenile justice system and in-patient facilities.[6]

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[1] Manson, S.M. (2004). *Cultural Diversity Series: Meeting the Mental Health Needs of American Indians and Alaska Natives.* National Association of State Mental Health Program Directors (NASMHPD) and the National Technical Assistance Center for State Mental Health Planning.

[2] Institute of Medicine (2002). *Reducing suicide: A national imperative.* Goldsmith, S. K., Pellmar, T. C., Kleinman, A. M., Bunney, W. E. (Eds.) Washington, DC: National Academies Press.

[3] U.S. Department of Health and Human Services. (2001). *Mental Health: Cultural, race, and ethnicity supplement to mental health: Report of the Surgeon General.* Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

[4] Manson, S.M. (2004). *Cultural Diversity Series: Meeting the Mental Health Needs of American Indians and Alaska Natives.* National Association of State Mental Health Program Directors (NASMHPD) and the National Technical Assistance Center for State Mental Health Planning.

[5] Ibid.

[6] Ibid.

The Indian Health Service is most directly responsible for providing mental health services to American Indians and Alaska Natives. The purpose of the IHS Mental Health/Social Service (MH/SS) program is to support the unique balance, resiliency, and strength of our American Indian and Alaska Native (AI/AN) cultures. The MH/SS program is a community-oriented clinical and preventive mental health service program that provides primarily outpatient mental health and related services, crisis triage, case management, prevention programming, and outreach services. The MH/SS program provides general executive direction and recruitment of MH/SS program staff to 12 Area Offices (regional) that, in turn, provide resource distribution, program monitoring and evaluation activities, and technical support to 163 Service Units. These Service Units consist of IHS, Tribal, and urban Indian programs whose MH/SS staff are responsible for the delivery of comprehensive mental health care to over 1.9 million American Indians and Alaska Natives.

The most common MH/SS program model is an acute, crisis-oriented outpatient service staffed by one or more mental health professionals. Many of the IHS, Tribal and Urban (I/T/U) mental health programs that provide services in times of crises do not have enough staff to operate 24/7. Therefore, when an emergency occurs, the clinic and service units will often contract out such services to non-IHS hospitals and crisis centers. Inpatient services are often purchased from non-IHS hospitals or provided by State or County mental health facilities. Medical and clinical social work in the MH/SS program model are usually provided by one or more social workers who assist with discharge planning and provide family intervention for child abuse, suicide, domestic violence, parenting skills, and marital counseling.

The MH/SS program model also includes tele-behavioral health technology. Telebehavioral health technology is increasingly adopted throughout the Indian health system to improve access to behavioral health services. Currently, over 30 IHS and Tribal facilities in 8 IHS Areas are augmenting on-site behavioral health services with tele-behavioral health services. This type of system capacity building supports not only distance psychiatric services to remote communities where such services are not available now but can also be used to share resources more efficiently in urban and semi-urban areas. A National Telebehavioral Health Center of Excellence is in the planning stages and should provide increased access to televideoconferencing based behavioral health services such as telepsychiatry.

Over the last 15 years, most of the behavioral health programs have transitioned from IHS to local community control via Tribal contracting and compacting. Over half of the Tribes have administrative control over the delivery of the majority of mental health and substance abuse programs through tribal contracts and compacts. Such local programs are community based and have direct knowledge of their population and what interventions can be effectively implemented. It is clear then that Tribes, not IHS, are now primarily providing services to their communities. IHS now seeks to support those services with programs and program collaborations to bring resources to the communities themselves.

Addressing Suicide Among American Indians

Suicide is a complicated public health challenge with a myriad of contributors in American Indian/Alaska Native communities. Only the pursuit of a multi-targeted, coordinated, and persistent effort that is acutely aware of the cultural context of suicide and blends the best of traditional AI/AN healing wisdom and western public health tools is likely to succeed on a national basis. The losses caused by suicide affect us all and so the solutions must come from all of us working together.

IHS has five targeted approaches for suicide prevention and intervention:

- Assist I/T/Us in addressing suicide utilizing community level cultural approaches.
- Identify and share information on best and promising practices.
- Improve access to behavioral health services.
- Strengthen and enhance IHS' epidemiological capabilities.
- Promote collaboration between Tribal and urban Indian communities with Federal, State, national, and local community agencies.

To address youth suicide in Indian Country appropriately requires public health and community interventions as much as direct, clinical ones. Since 2003, the IHS National Suicide Prevention Initiative has provided a critical framework for addressing the tragedy of suicide in American Indian and Alaska Native communities. The IHS National Suicide Prevention Initiative builds on the foundation of the HHS "National Strategy for Suicide Prevention" and the 11 goals and 68 objectives for the Nation to reduce suicidal behavior and its consequences, while ensuring we honor and respect our people's traditions and practices.

Traditional knowledge, along with the role of Elders and spiritual leaders, needs to be respected and validated for the important role they play in healing and wellness. Understanding and decreasing suicide in our communities will require the best holistically and culturally sensitive, collaborative efforts our communities and the agencies that serve them can bring together. With these principles in mind, we hope to provide a holistic, cultural foundation to suicide prevention, building on the strong resilience of AI/AN communities. We will strive to bridge concepts between AI/AN communities, government agencies, and non-profit organizations in order to effectively prevent suicide.

The Suicide Prevention Initiative is complemented by the IHS Behavioral Health Initiative, both of which seek to address suicide prevention through a holistic, community-centered approach. Two other focus areas that are closely linked to the Behavioral Health Initiative are the Chronic Disease Management and Health Promotion and Disease Prevention Initiatives. All of these initiatives are pertinent to suicide prevention efforts and seek to address the underlying causes of poor physical and mental health, rather than just treating the symptoms. They also stress the empowerment and full engagement of individuals, families, and communities in health care.

Indian Health Service supports changing the paradigm of mental health services from being specialty and disease focused to being a part of primary care and the "Medical Home". This offers new opportunities for interventions that identify high risk individuals before their actions or behavior becomes more clinically significant. One primary care based behavioral health intervention is the Alcohol Screening Brief Intervention for patients presenting after physical trauma, which our agency is broadly promoting as an integral part of a primary care based behavioral health program. Studies suggest that this and similar interventions can dramatically reduce further traumatic injury as well as alcohol and other substance abuse more generally. The agency, through our Chronic Disease Collaborative and Innovations in Primary Care project, is also supporting efforts to integrate behavioral health providers directly into primary care settings as has been done successfully in Alaska and in other progressive primary care sites across the country. This presents a dramatic change from the usual model of distinct and separate medical and behavioral health service delivery and we intend to support this practice shift over the coming years through developing further learning communities, sharing implementation best practices as they develop, and re-aligning and supporting the development of primary care-based behavioral health resources.

We have made substantial efforts over the last several years to improve our behavioral health data collection in the Resource and Patient Management System (RPMS). Behavioral health information can now be integrated with primary care and other clinical information supporting coordinated care and improved health outcomes. As increasing numbers of clinics adopt the integrated model, data will become available that may help identify opportunities for intervention in medical, behavioral health, and community settings. IHS has developed a suicide surveillance reporting tool to document incidents of suicide in a standardized and systematic fashion which is available to all providers in the RPMS health information system. The Suicide Reporting Database is beginning to provide a more detailed picture of who is committing or attempting suicide and identifies salient factors contributing to the events. Accurate and timely data captured at the point of care provides important clinical and epidemiological information that can be used to inform intervention and prevention efforts. IHS is currently developing an IHS-wide Behavioral Health "data mart" to provide IHS leadership with up-to-date information on suicidal events including suicide completions. The application will include a number of available reports and will provide the ability to identify "cluster" events to assist in the mobilization and deployment of available resources. Finally, IHS GPRA measures now include screening for depression in primary care settings as best practice in order to assist in identifying patients at risk for developing suicidal ideation. Tools have been selected to assess depression, monitor response, track such response over time, and are incorporated into the IHS Electronic Health Record. IHS has consistently met or exceeded target goals for this GPRA depression screening measure. This level of monitoring is key to identifying at risk populations by providers and ensuring they receive timely and adequate care.

The IHS Emergency Services Program is supporting AI/AN communities by utilizing the IHS Emergency Response to Suicide Model to assess communities with high incidence of suicide, coordinate a response to the affected community, and augment existing staff, with the goal of mitigating the emergency and stabilizing the community. For example, in FY 2008, the IHS Emergency Services staff managed on behalf of HHS the deployment of Public Health Service mental health clinicians through the Office of Force Readiness and Deployment (OFRD) to a Tribal commu-

nity from January–May 2008 to respond to a suicide "cluster" in that community. Federal and community efforts are still ongoing in that community. The deployment was directly requested by that Tribal government, and HHS' response was coordinated through the Office of Intergovernmental Affairs.

Substantial progress has been made in developing plans and delivering programs, but it is still only the beginning of a long term, concerted and coordinated effort among Federal, Tribal, State, and local community agencies to address the crisis. We have recognized that developing resources, data systems, and promising programs, as well as sharing information across the system, requires national coordination and leadership. In response to the problem, the IHS, with Federal partners, Tribal, and Urban Indian communities across the country, will expand ongoing partnerships and formulate long term strategic approaches to intervene in the suicide crisis and provide suicide prevention and early intervention activities.

Last year, I established the National Tribal Advisory Committee (NTAC) on Behavioral Health made up of Tribal Leaders from each IHS Area. The Committee serves as an advisory body to the Indian Health Service, providing expertise, guidance, and recommendations on behavioral health issues affecting the delivery of health care for AI/ANs. In addition, the National Behavioral Health Workgroup was established which is comprised of Tribal and Urban behavioral health service providers. The workgroup provides information to the National Tribal Advisory Committee on Behavioral Health on issues in Indian Country.

To help guide the overall Indian health system effort, the National Suicide Prevention Committee, comprised of suicide prevention experts, was established. The Committee was tasked with identifying and defining the steps needed to build on the previous suicide prevention efforts to significantly reduce the impact of suicide and suicide-related behaviors on AI/AN communities. Members of the Suicide Prevention Committee are interdisciplinary and represent a broad geographic distribution within and outside the Indian health system.

It is the responsibility of the IHS Suicide Prevention Committee to provide recommendations and guidance to the Indian Health Service regarding suicide prevention and intervention in Indian Country. This past year, the SPC developed an Indian Health System National Suicide Prevention Strategic Plan. The National Suicide Prevention Strategic Plan is a first step in describing and promoting the accumulated practice-based wisdom in AI/AN communities. At its best, the plan will be a living and constantly changing reflection of the collaborative and focused efforts of the many people throughout American Indian/Alaska Native communities who are working to reduce the scourge of suicide.

The Methamphetamine and Suicide Prevention Initiative (MSPI) is a another coordinated program designed to provide prevention and intervention resources for Indian Country. This initiative promotes the development of evidence-based practices using culturally appropriate prevention and treatment to address methamphetamine abuse and suicidal behaviors in a community-driven context.

The goal is to intervene effectively to prevent, reduce or delay the use and/or spread of methamphetamine abuse by increasing access to methamphetamine and suicide prevention services through culturally relevant services. The $14 million initiative focuses on supporting promising or model practices for methamphetamine and suicide reduction programs in Indian Country.

So, taken all together, where are we?

We acknowledge that the complexity of suicide and its close cousins, violent and accidental death and injury, remains challenging. At the same time, we believe suicide and suicidal behaviors are preventable through the engagement of the affected communities and the application of research-supported public health approaches. Several Tribal and urban Indian communities have already taken up this challenge and have been implementing a number of innovative and culturally sensitive prevention initiatives. For example, Tribal and urban Indian communities are implementing the Native H.O.P.E. curriculum, the American Indian Life Skills Development, the Sources of Strength model, ASIST (Applied Suicide Intervention Skills Training), QPR (Question, Persuade, Refer), and other promising approaches in several communities across Indian Country. Increasing access to services, improving responsiveness of services, developing school and community level wisdom about how to manage distressed community members, educating and increasing awareness, and connecting young people to their culture are all successful approaches in Indian Country that are beginning to show us the way. However, for many other individuals and groups, it remains challenging to determine the best approach to prevent suicide in their own communities.

The initiatives and programs that I have described here are some of the methods and means to engage individuals and their communities. These efforts are not sufficient in and of themselves to significantly change many peoples' living conditions.

However, if we can act together, among agencies, branches of government, Tribes, States, and communities, I believe that the tide can be turned and hope restored to those who have lost hope. To that end, I commit to work with you and anyone else in and out of government to bring services and resources to that effort.

Mr. Chairman, this concludes my statement. Thank you for this opportunity to discuss youth suicide in Indian Country. I will be happy to answer any questions that you may have.

The CHAIRMAN. Mr. McSwain, thank you very much.

Next, we will hear from Dr. Eric Broderick from SAMHSA.

Thank you very much for being here.

STATEMENT OF ERIC B. BRODERICK, D.D.S., M.P.H., ACTING ADMINISTRATOR, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Dr. BRODERICK. Good morning, Mr. Chairman and Committee members. Thank you very much. I appreciate the opportunity to be here today. I thank you for bringing together survivors of suicide, professionals from the suicide prevention field, as well as Mr. McSwain and other Federal partners to talk about this issue.

No one person has the answer to this. No one organization. It must be reliant on collaboration, a collaborative effort that people bring from many different perspectives to address this very, very serious issue.

SAMHSA has worked very hard over the last three years to put our resources out into the field in Indian Country to ultimately help increase the capacity of Indian communities to address the challenges that mental illness and substance abuse present to them.

Suicide is a serious public health challenge, as has been said today, and it is only now beginning to receive the attention and degree of national priority that it deserves. It takes huge courage to do what Senator Reid did, what Ms. Jetty did, and what her family did, what the gentleman that Senator Murkowski and I heard last week did, to stand up, in spite of the stigma, in spite of the guilt and the anger and grief that a family feels, and speak out. Until that happens, the stigma will remain.

I am very pleased to hear it happening more and more and more across this Country because that is what will actually deal with the stigma and deal with the many different emotions that families confront when confronted with this great problem.

Suicide is a huge problem in this Country, with 32,000 deaths a year. You heard Senator Reid state that statistic. Any time there is a situation where 900,000 of our youth, 900,000 a year, plan their own death, and 712,000 of those youth actually attempt it, that, I would say, qualifies as a public health crisis. You have very well articulated the needs of this Country to face this issue.

We have heard the data, and I won't repeat them, but as seriousness as this condition is across this Country, the situation is more serious in Indian communities. I have said that we have made it a priority at SAMHSA to make our resources available in Indian Country. As we do that, it is critical that we engage tribes and tribal leaders to help assure that we do so in a respectful way as partners. I want to mention a few strategies that we have used to engage tribes in that way.

We have a Tribal Advisory Committee that is comprised of 14 tribal leaders from around the Country, to provide us advice and guidance. We participate in the HHS Tribal Consultation Sessions each year around the Country.

We also in 2006 partnered with the Department of Justice to be responsive to a call from tribal leaders to improve tribal capacity and infrastructure through training and technical assistance to tribal communities. That project, now called the Tribal Justice Safety and Wellness Project, began with a meeting in California two and a half years ago where 200 people attended. Mr. McSwain talked about the session that we had in Billings last summer. The session was convened, by the Department of Interior, the Department of Health and Human Services, and the Department of Justice. Over 1,000 people came together who don't talk to one another including Federal agencies, to allow tribes the access that they have requested to talk to individuals from multiple locations across the Executive Branch of the government.

The partnership now includes the Department of Health and Human Services, the Department of Justice, the Department of Interior, the Department of Housing and Urban Development, the Small Business Administration, and our newest partner, the Corporation for National and Community Service.

I will tell you at every one of these opportunities, these venues where tribes come together with Federal staff, suicide is among the most frequently mentioned issues that is brought to us along with requests to help tribes address that.

We are making progress. At the start of 2005, SAMHSA had two suicide prevention grants. Today, we have 110. You have heard much discussion about the Garret Lee Smith Suicide Prevention Act. There have been others who talked about the Suicide Prevention Resource Center that SAMHSA funds. It is a technical assistance center. What I would add to that is there are now two tribal affairs specialists employed by the Suicide Prevention Resource Center specifically there to help Indian communities with their requests for technical assistance around suicide.

You have heard some discussions about the Native Aspirations Project. That project focuses on the 25 communities with very high risk for suicide clusters. They do wonderful work. I would add that some of the Native Aspiration communities have gone on and used that technical assistance and gone on to become Garret Lee Smith grant awardees.

The situation today at SAMHSA is that fully one-third of our Garret Lee Smith State and tribal grants go to tribes. We awarded 30 last year, 12 went to tribes, 18 went to States. And as Senator Murkowski said, we were in Alaska last week and presented a $1.5 million Garret Lee Smith grant to the State of Alaska. One of the first things that they told us was in using those grant dollars, they will put them in place in communities where the need exists. They made it very clear that native communities are among the communities that they will focus on. So it is very heartening to see resources going out in that way to communities in very great need.

The last program I would like to talk about is the National Suicide Prevention Lifeline Network, a network of 135 crisis centers across the United States that receive calls from a national toll-free

number, number 1–800–273–TALK. Every month, 44,000 people have their calls answered by the lifeline, an average of 1,439 people a day. Calls are free and confidential and answered 24 hours a day, 7 days a week. We know this program saves lives.

The National Suicide Prevention Lifeline American Indian Initiative has worked to promote access to suicide prevention hot line services in Indian Country by supporting communication and collaboration between tribes and local crisis centers, as well as providing outreach materials customized to each tribe.

Suicide is preventable and help is available. All Americans have access to the National Suicide Prevention Lifeline during times of crisis, and we are committed to sustaining this vital national resource.

These SAMHSA initiatives are an important start, but as we know, there is much, much more to be done to reduce the tragic burden of suicide in Indian Country. The problems confronting the American Indians and Alaska Natives are taking a toll on these communities now and will in the future. I lived on the Wind River Reservation when the incident occurred in 1985 that the Senator talked about a few minutes ago. I will tell you, in my opportunities to go back there, much has been done to remedy that situation, but they still live with the outcomes and the consequences of those 10 or so young people who killed themselves all those many years ago.

Mr. Chairman, I want to thank you for the opportunity to be here today. I would be happy to answer any questions that you might have or the Committee might have. Thank you very much.

[The prepared statement of Dr. Broderick follows:]

PREPARED STATEMENT OF ERIC B. BRODERICK, D.D.S., M.P.H., ACTING ADMINISTRATOR, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. Chairman and Members of the Committee, good morning. I am Dr. Eric Broderick, Acting Administrator of the Substance Abuse And Mental Health Services Administration (SAMHSA) within the Department of Health and Human Services (HHS) and Assistant Surgeon General. I am pleased to have this time to share with you a few highlights of SAMHSA's efforts and the Agency's important role in improving behavioral health throughout American Indian/Alaska Native (AI/AN) communities.

In my prior position as SAMHSA's Deputy Administrator and twice now as the steward of the Agency as Acting Administrator, I have worked hard to raise the critical issues facing our tribal nations surrounding behavioral healthcare and its direct relationship to overall health to a priority level within SAMHSA and among our federal partners. I have made it a priority to take SAMHSA and its resources directly to AI/AN communities where much-needed training and dialogue can and has taken place to further the process of breaking down the barriers to quality assistance and services.

By participating annually in the HHS Budget Consultation and Regional Consultation Sessions with Tribal leaders and representatives, SAMHSA hears firsthand about the top priorities in Indian Country. Additionally, SAMHSA requires active engagement of our Senior Leaders in these meetings and has made this a part of all of our performance plans.

I continue to believe one of my most important responsibilities is to leave each site visit, training session, consultation session or other gathering knowing more about what needs to be done in AI/AN communities than when SAMHSA staff and I arrived. The need for those at the federal level to continue engaging tribal leaders, organizations and communities is clear and the response should be held at a high level of importance.

In particular, over the past two years SAMHSA has gained ground on a number of accomplishments with our tribal partners including our partners within the IHS Regional Health Boards. For instance, in 2006 the Department of Justice and

SAMHSA began a collaboration to respond to the call of tribal leaders to improve tribal capacity and infrastructure through training and technical assistance to tribal communities. With more federal agencies committing to developing strategic solutions for American Indians and Alaska Natives, the collaboration is now a multi-agency endeavor entitled *Tribal Justice, Safety and Wellness Government-to-Government Consultation, Training and Technical Assistance Sessions.* In 2006 about 200 people attended the first session. By the seventh session, there were over 1,000 people, which demonstrates that a collaborative approach is working–no one agency can solve the problems alone.

These Tribal Training and Technical Assistance Sessions provided many opportunities for tribal leaders to learn about SAMHSA's grant programs as well as important information regarding grants administration and financial management, tips for successful grant writing, overviews of various Federal funding sources and information on Tribal Drug Courts. There are many federal partners including: the Department of Health and Human Services through SAMHSA, the Indian Health Service and the Office of Minority Health; the Department of Justice through its Office of Justice Programs, Community Orienting Policing Services, Executive Office of U.S. Attorneys Native American Issues Subcommittee, Office of Tribal Justice, and Office on Violence Against Women; the Department of the Interior through its Bureau of Indian Affairs; the Department of Housing and Urban Development through its Office of Native American Programs; the Small Business Administration's Office of Native American Affairs; and our newest federal partner, the Corporation for National and Community Service.

Many of these and other steps forward taken by SAMHSA are a result of the agency's dedication to improve services in Indian Country beginning with the revision of SAMHSA's Tribal Consultation Policy in 2007. SAMHSA has established a Tribal Technical Advisory Committee comprised of Tribal Leaders who provide guidance and input on critical issues impacting Indian Country. As we continue to move forward and continue to make progress, we will stay closely involved in the critical issues, such as suicide, which continue to face our tribal partners.

SAMHSA is working to address suicide among American Indians and Alaska Natives. SAMHSA's efforts correspond with the efforts identified in the National Strategy for Suicide Prevention (NSSP). The NSSP represents the combined work of advocates, clinicians, researchers and survivors around the nation. The NSSP provides a framework for action to prevent suicide and guides development of an array of services and programs that must be developed. It is designed to be a catalyst for social change with the power to transform attitudes, policies, and services. SAMHSA's agency-wide efforts to address and prevent suicide continue to be developed around the recommendations of the NSSP.

Suicide—Correlation with Substance Use and Mental Health Disorders

SAMHSA is responsible for improving the accountability, capacity and effectiveness of the nation's substance abuse prevention, addictions treatment, and mental health service delivery systems. Suicide prevention is among our agency priorities.

SAMHSA has a clear role to play in addressing and preventing suicide, as both substance abuse and mental health disorders can increase the risk of and contribute to suicidal behavior in several ways. Two of the leading risk factors for suicide are a history of depression or other mental illness and alcohol or drug abuse. For particular groups at risk, such as American Indians and Alaska Natives, depression and alcohol use and abuse are the most common risk factors for suicide.

Suicide—A Public Health Issue

Suicide is a serious public health challenge that is only now receiving the attention and degree of national priority it deserves. Many Americans are unaware of suicide's toll and its global impact. Suicides account for up 49.1 percent of all violent deaths worldwide, making suicide the leading cause of violent deaths, outnumbering homicide. In the United States, suicide claims approximately 32,000 lives each year. When faced with the fact that the annual number of suicides in our country now outnumbers homicides by three to two, the relevance and urgency of our work becomes clear. Additionally, when we know, based on SAMHSA's National Survey on Drug Use and Health (NSDUH) in 2003, that approximately 900,000 youth had made a plan to commit suicide during their worst or most recent episode of major depression and an estimated 712,000 attempted suicide during such an episode of depression, it is time to intensify activity to prevent further suicides. The NSDUH data and the countless personal stories of loss and tragedy are proof that suicide prevention must remain a priority at SAMHSA.

Suicide Among American Indian and Alaska Native Youth

Suicide is now the second-leading cause of death (behind unintentional injury and accidents) for American Indian and Alaska Native youth aged 10–34. HHS's Centers for Disease Control and Prevention (CDC) reports that from 1999 to 2004, the suicide rate for American Indians/Alaska Natives was 10.84 per 100,000, higher than the overall U.S. rate of 10.75. Adults aged 25–29 had the highest rate of suicide in the American Indian/Alaska Native population, 20.67 per 100,000. Suicide ranked as the eighth-leading cause of death for American Indians/Alaska Natives of all ages.

Of significant concern is that in the two most recent years for which we have data, 2004 and 2005, the suicide rate among American Indians/Alaska Natives increased. According to CDC's National Vital Statistics Report, in 2005 American Indian and Alaska Native youth aged 15–24 had a rate of suicide twice as high as youth of that age nationally. We do not yet know if the 2006 data will show a continuation of the same tragic trend, but the stories we have heard lead us to have great concern. What in and of itself is a tragedy to report is more than one-half of all persons who die by suicide in the United States, and an even higher number in Tribal communities, have never received treatment from mental health providers.

SAMHSA's Role in Better Serving American Indian and Alaska Native Populations

SAMHSA focuses attention, programs, and funding on improving the lives of people with or at risk for mental or substance use disorders. SAMHSA's vision is "a life in the community for everyone." The agency is achieving that vision through its mission of "building resilience and facilitating recovery." SAMHSA's direction in policy, program, and budget is guided by a matrix of priority programs and cross-cutting principles that include the related issues of cultural competency and eliminating disparities. To achieve the agency's vision and mission for all Americans, SAMHSA-supported services are provided within the most relevant and meaningful cultural, gender-sensitive, and age-appropriate context for the people being served. SAMHSA has put this understanding into action for the American Indian and Alaska Native communities it serves. SAMHSA has worked to ensure Tribal entities are eligible for all competitive grants for which States are eligible.

SAMHSA's activity in suicide prevention has increased dramatically in recent years. For example, at the start of 2005, there were two competitive grant awards for suicide prevention. At the end of 2005, there were 46. Currently, there are over 110 suicide prevention grants going to states, tribes/tribal organizations, territories, and colleges and universities, and crisis centers across the country. SAMHSA supports four major suicide prevention initiatives that I will highlight briefly today. These initiatives are: the Garrett Lee Smith Youth Suicide Prevention Grant Program; SAMHSA's the Native Aspirations Project; the Suicide Prevention LifeLine; and the Suicide Prevention Resource Center.

Garrett Lee Smith Youth Suicide Prevention Grant Program

As a result of the Garrett Lee Smith Memorial Act (P.L. 108–355), SAMHSA has been working with State and local governments and community providers to stem the number of youth suicides in our country. In 2005, we awarded the first cohort of grants, 14 in all, under the Garrett Lee Smith Memorial Act State/Tribal Suicide Prevention program. These funds are available to help States/Tribes implement a State-wide/Tribe-wide suicide prevention network. One of those first set of grants went to the Native American Rehabilitation Association in Oregon. In addition, through an Interagency Agreement between the CDC and SAMHSA, the Native American Rehabilitation Association was one of three Garrett Lee Smith grantees awarded additional funding to enhance their evaluations to maximize what we can learn from these important suicide prevention efforts.

Awards were also made in 2006 and 2007, during which six more Tribes/Tribal Organizations were awarded grants. These grants are supporting a range of suicide prevention activities in Indian Country, such as training community members to recognize the warning signs of suicide and intervening with youth seen in Emergency Departments who have attempted suicide. This past August (2008), 12 Tribes/Tribal Organizations received Garrett Lee Smith grants in addition to the 18 grants made to States, totaling 30 new awards.

Garrett Lee Smith grants to Tribes and Tribal Organizations now total one-third of the number of grant awards. This is not only a direct result of outreach and technical assistance, but a true indication of the resolve of Tribes and Tribal Organizations to proactively seek RFAs and then put forward strong, viable applications. Additionally, it is important to note that many of the states that received grant awards are partnering with and/or reaching out to include suicide prevention efforts in their

local tribal communities. Among the 18 States that received a grant in 2008 is Alaska. Just last week, I was able to travel to Juneau to present to the State of Alaska, with Senator Murkowski in attendance, this $500,000 per year award for three years, totaling $1.5 million.

Within the newest cohort of grants, the Tribes/Tribal Organizations awardees are: the Gila River Behavioral Health Authority Youth Suicide Prevention Project, The Gila River Indian Community, Sacaton, Arizona; Omaha Nation Community Response Team—Project Hope, Walthill, Nebraska; Mescalero Apache School Youth Suicide Prevention and Early Intervention Initiative, Mescalero, New Mexico; Wiconi Wakan Health & Healing Center, Rosebud Sioux Tribe, Rosebud, South Dakota; Circle of Trust Youth Suicide Prevention Program, The Confederated Salish Kootenai Tribes of the Flathead Indian Nation, Pablo, Montana; Preserving Life: Nevada Tribal Youth Suicide Prevention Initiative, Inter-Tribal Council of Nevada, Sparks, Nevada; Youth Suicide Prevention, The Crow Creek Sioux Tribe, Ft. Thompson, South Dakota; Tribal Youth Suicide Prevention Program, Oglala Sioux Tribe, Pine Ridge, South Dakota; Wiconi Ohitika Project, Cankdeska Cikana Community College, Fort Totten, North Dakota; Sault Tribe Alive Youth (STAY) Project, Sault Ste Marie Tribe Chippewa Indians, Sault Ste Marie, Michigan; Bering Strait Suicide Prevention Program, Kawerak, Inc., Nome, Alaska; and the Native Youth Suicide Prevention Project, Native American Rehabilitation Association, Portland, Oregon, which successfully recompeted for a second grant.

As of October 2, 2008, a total of 54 states, tribes, and tribal organizations, as well as 49 colleges and universities, will be receiving funding for youth suicide prevention through this program. Again, it is important to note that with the new tribal grantees, one-third of all of the Garrett Lee Smith State and Tribal grants will be going to tribes or tribal organizations.

Native Aspirations Project

SAMHSA funds the Native Aspirations project, which is a national project designed to address youth violence, bullying, and suicide prevention through evidence-based interventions and community efforts. Native Aspirations, after consultation with SAMHSA based on data from IHS, determines the 25 AI/AN communities that are the most "at risk", and the project then helps these communities develop or enhance a community-based prevention plan. After a community is selected, the initial step is a visit from Native Aspirations project staff members, who share information and help community leaders set up an oversight committee. The second step is a Gathering of Native Americans (GONA), a 4-day event designed to offer hope, encouragement, and a positive start. GONA events are based on each community's traditional culture and honor AI/AN values. GONA events are a safe place to share, heal, and plan for action.

Within a month of a GONA, Native Aspirations staff facilitate a 2-day planning event. At this point, participants receive training about prevention plans and decide which model to follow. They outline a customized plan based on actions that have worked for others. As the community finalizes and carries out its plan, Native Aspirations provides training, consultation, technical assistance, and budget support. A number of tribes who received help through Native Aspirations were able to build on this to successfully compete for a Garrett Lee Smith Youth Suicide Prevention grant.

Suicide Prevention Resource Center

Another initiative is the Suicide Prevention Resource Center (SPRC), a national resource and technical assistance center that advances the field by working with states, territories, tribes, and grantees and by developing and disseminating suicide prevention resources. The SPRC was established in 2002. It supports suicide prevention with the best of available science, skills and practice to advance the National Strategy for Suicide Prevention (NSSP). SPRC provides prevention support, training, and resource materials to strengthen suicide prevention networks and is the first federally funded center of its kind.

The Suicide Prevention Lifeline

The National Suicide Prevention Lifeline is a network of 135 crisis centers across the United States that receives calls from the national, toll-free suicide prevention hotline number, 800–273–TALK. The network is administered through a grant from SAMHSA to Link2Health Solutions, an affiliate of the Mental Health Association of New York City. Calls to 800–273–TALK are automatically routed to the closest of 135 crisis centers across the country. Those crisis centers are independently operated and funded (both publicly and privately). They all serve their local communities in 47 states, and operate their own local suicide prevention hotline numbers. They

agree to accept local, state, or regional calls from the National Suicide Prevention Lifeline and receive a small stipend for doing so.

In the three states that do not currently have a participating crisis center (Idaho, Hawaii, and Vermont), the calls are answered by a crisis center in a neighboring state. Every month, more than 44,000 people have their calls answered through the National Suicide Prevention Lifeline, an average of 1,439 people every day. When a caller dials 800–273–TALK, the call is routed to the nearest crisis center, based on the caller's area code. The crisis worker will listen to the person, assess the nature and severity of the crisis, and link or refer the caller to services, including Emergency Medical Services when necessary. If the nearest center is unable to pick up, the call automatically is routed to the next nearest center. All calls are free and confidential and are answered 24 hours a day, 7 days a week.

By utilizing a national network of crisis centers with trained staff linked through a single national, toll-free suicide prevention number, the capacity to effectively respond to all callers, even when a particular crisis center is overwhelmed with calls, is maximized. This also provides protection in the event a crisis center's ability to function is adversely impacted, for example, by a natural disaster or a blackout. Further, by utilizing the national number 800–273–TALK, national public awareness campaigns and materials can supplement local crisis centers' efforts to help as many people as possible learn about and utilize the National Suicide Prevention Lifeline. In fact, SAMHSA has consistently found that when major national efforts are made to publicize the number, the volume of callers increases and this increased call volume is maintained over time.

The National Suicide Prevention Lifeline's American Indian initiative has worked to promote access to suicide prevention hotline services in Indian Country by supporting communication and collaboration between tribes and local crisis centers as well as providing outreach materials customized for each tribe. We are pleased that we have been able to work together with the AI/AN Communities and also with the Department of Veterans Affairs to help deliver the critically important messages that suicide is preventable, and that help is available. All Americans have access to the National Suicide Prevention Lifeline during times of crisis, and we are committed to sustaining this vital, national resource.

SAMHSA Emergency Response Grants

SAMHSA is also committed to assisting communities which have faced traumatic events through our SAMHSA Emergency Response Grant (SERG) Program. SAMHSA provides SERG funding in rare emergency situations in which State and local resources are overwhelmed and no other Federal resources are available. Applicants must demonstrate that the need is greater than existing local and State resources, and must explain why other Federal funding doesn't meet their needs. The SERG is a SAMHSA-wide program. Funding can be used for emergency mental health services and disaster-related substance abuse treatment and prevention programs and can be used to address new substance abuse treatment and prevention concerns in response to an event or to replace services destroyed by a disaster.

The SERGs are available in response to those situations in which a presidential disaster declaration has not been made and are particularly helpful in cases of emergent and urgent unmet behavioral health needs of communities such as the Red Lake reservation community. The Red Lake Band of Chippewa Indians in Minnesota received a SERG in response to the school shooting there. The SERG assisted in the establishment of the Wii-doo-kaa-wii-shin (Helping Each Other) Project. This project provides mental health needs, specialized outreach, assessment, ongoing support and education, as well as treatment and services.

The Standing Rock Sioux also received a SERG in response to a suicide cluster. The grant assisted with the establishment of a behavioral health network with staffing as well as funding to augment their suicide prevention program, crisis hotline, healing and support, as well as training and technical assistance. In addition, the Crow Creek Sioux received a SERG to assist in their efforts to protect and heal their community following a suicide cluster as well.

The SAMHSA initiatives described above are important steps to reduce the tragic burden of suicide in Indian Country. The problems confronting American Indians and Alaska Natives are taking a toll on the future of these communities.

Mr. Chairman and Members of the Committee, thank you for the opportunity to appear today. I will be pleased to answer any questions you may have.

The CHAIRMAN. Dr. Broderick, thank you very much for being here.

Let me ask briefly about the response to the Rosebud circumstance in South Dakota. The suicide rates on the Rosebud Reservation reached epidemic proportions there. I wonder about the emergency response. What is the level of suicide? What is the approach you use by which the IHS would implement some sort of emergency response model that you have? And describe to us what you did at Rosebud, if you would.

Dr. BRODERICK. Okay. The situation at Rosebud has been going on for some time. It is not something that just recently started. Actually, the Rosebud Sioux Reservation is one of the communities that is part of the Native Aspirations Project. So in partnership with the Indian Health Service, we increased the resources available to that community through Native Aspirations. There was a deployment of commissioned officers of the Public Health Service to go and assist that community.

The CHAIRMAN. But how did that happen? What was the trigger that caused it?

Dr. BRODERICK. The tribe asked. It is a matter of the tribe asking the Commission Corps. The Indian Health Service was intimately involved in that request, and Public Health Service officers from SAMHSA, and quite frankly all across the Department of Health and Human Services responded to go to Rosebud for tours of three to four weeks and rotations of individuals to provide mental health and substance abuse counseling services to that community over the course of time.

The process continues. It is hard work, because we believe that the solution to the problem doesn't rest at SAMHSA or doesn't rest at the Indian Health Service headquarters in Rockville. It rests in that community. And we stand ready and committed to provide assistance to the community.

The Department of Health and Human Services also convened in the Office of Intergovernmental Affairs a cross-agency collaboration of multiple departments to bring resources to bear to help that community.

The CHAIRMAN. We will know we have made progress when we see diminished rates of teen suicides on Indian reservations. The question I have is, with several different initiatives out there that are being used by SAMHSA and the Indian Health Service, how are we tracking the effectiveness and the efficiency of the use of these funds? How do we know what we are getting for these funds and whether we are making a difference? And which programs, which initiatives make the biggest difference?

Dr. BRODERICK. For SAMHSA, each of our grants, each of our grant programs, rely on evidence-based practice. We heard some discussion about that earlier. What can we do when the evidence-based practices are developed in non-native communities to make them available? That is a whole other discussion, but suffice it to say that our grantees, in order to be successful for a SAMHSA grant, you must demonstrate the use of evidence-based practice.

We then monitor progress on those grants through the Government Performance and Results Act and the PART process to make sure that data are available and that the projects are successful.

The CHAIRMAN. Mr. McSwain?

Mr. MCSWAIN. Thank you, Mr. Chairman. I think Indian Health Service certainly has two things working. One is that we have always been there with our clinical folks and the like, so we are looking at a system of care that begins to identify certain incidences. Maybe it is depression. We are tracking that on the clinical side, so we can hand them off, a soft hand-off to our behavioral health people, and even incorporating the behavioral health people in.

We have built in the evaluation piece into these grants. The first $14 million that we got this last year, we will build it into those and actually begin to measure results as they go out to the communities with this very thought in mind.

The CHAIRMAN. How short are your behavioral health dollars in order for the reach that you should do? We talked earlier about rationing. I know these programs exist. I know that both of you do outreach on certain reservations, they get some help from you. I also know that is not something that is across the Indian populations and available to all reservations.

So how short are we of the resources necessary to do the job you think should be done?

Mr. MCSWAIN. You know, I don't really know. The reason why I don't know is that because of the fact that there are so many other factors involved. Health is one piece of it. Until we get the whole pie built, if you will, the SAMHSAs, the DOJs, and all the other folks who enter in to helping a community with suicide, when we get that all together, if we take all the pieces, then we would have what we would project we would need.

The CHAIRMAN. You have heard and you know of the models that are out there, the work that is being done to train folks in our schools and so on. There must be some notion of what kind of additional resources should be made available so that we better expose all of the populations that are at risk out there to the kinds of services that are necessary, the kinds of programs that are necessary.

Would you work to try to give us your assessment of what that shortage of resources is at this point?

Mr. MCSWAIN. I certainly would give it a big try because it is a fact that we work so hard on the clinical side. We can tell you what the numbers are there, but giving you the behavioral health side will take a little more work, but we can do that.

The CHAIRMAN. Unfortunately, because of the vote and the recess we felt this would go from 10 a.m to 12 noon. It is 12:20 p.m. The Chair had a 12 o'clock speech that I didn't give off the Hill, but I have to chair a luncheon in the Capitol Building.

So what I would like to do for both of you is to submit a list of questions. I think what we have done today is hear a lot of information with which we can try to evaluate what is happening and what works, what doesn't work. We have heard from a young woman who described these issues in personal terms, and the reason that is important, especially here in Washington, D.C. where we describe them statistically. That is not what is happening in America. This isn't about statistics. It is about great tragedy that is occurring, not only those who take their lives and lose their lives, but those who are left behind as victims of these suicides.

So I want to thank both of you for being willing to sit through the previous testimony. That is not usual, but I think it was for good purpose. We will submit a list of additional questions to you.

I want to thank all of the others who have testified.

Our Committee is going to continue to pay attention to this, even as we turn now to try to write a new Indian Health Care Improvement bill that we will introduce. As we do that, we will pay special attention to this subject, which is part of that issue.

This hearing is adjourned.

[Whereupon, at 12:20 p.m., the Committee was adjourned.]

A P P E N D I X

PREPARED STATEMENT OF JACQUELINE S. GRAY, PH.D., ASSISTANT PROFESSOR, CENTER FOR RURAL HEALTH, UNIVERSITY OF NORTH DAKOTA SCHOOL OF MEDICINE AND HEALTH SCIENCES

Greetings Honorable Chairman Dorgan, Vice-Chairman Barrasso, and Members of the Committee. Thank you for the opportunity to provide testimony to this committee and my perspective on the present status and progress toward preventing American Indian and Alaska Native (AI/AN) youth suicidal behavior.

I bring to you my perspectives as a Choctaw and Cherokee descendent, a mental health clinician with 25 years of experience working with American Indian clients, a faculty member from the Center for Rural Health at the University of North Dakota focused on rural and tribal mental health issues, an adjunct faculty in counseling psychology preparing future mental health professionals, a researcher of mental health and suicide prevention with American Indians, and a concerned mother and grandmother. I have worked in suicide prevention and crisis intervention for 20 years and developed a crisis intervention model that has been adopted across the state of Oklahoma. I have worked with Garrett Lee Smith campus, state, and tribal suicide prevention programs, Native Aspirations (which utilizes Dr. Theresa LaFromboise's *American Indian Life Skills* [LaFromboise, 1996] curriculum), Indian Health Service, and tribal programs focused on behavioral health. I walk in many worlds with regard to this issue: Native and Western with my bicultural identity; clinician, teacher, researcher, and consumer of mental health services; survivor of suicide; promoter of wellness, and prevention of suicide. I hope my testimony will assist the Committee in understanding the needs and potentials related to AI/AN youth suicide and promotion of positive AI/AN mental health.

You have received statistics from others highlighting the suicide rates of AI/AN youth as the highest in the nation and escalating in recent years (Broderick, LaFromboise, McSwain, Reid, Walker, 2009). Suicide in AI/AN communities is an epidemic and in need of the attention given a public health epidemic. A great deal has been addressed in recent years by the Garrett Lee Smith Memorial Act (P.L. 108–355). I have worked with campus, state, and tribal applicants and awardees of these grants and know the hard work that is being done to address youth suicide through the funds provided. I have worked with the Native Aspirations program and know that they are trying to address suicide prevention in some of the most "at risk" AI/AN communities in the country. I have also worked with the Suicide Prevention Resource Center and Suicide Prevention Lifeline and the great work they are doing to provide resources and support for suicide prevention. But this is clearly not enough.

Services

Mental health services available through Indian Health Service (IHS) and tribes are already stretched beyond capacity. As more youth are identified as suicidal or at risk we need more local services to address those needs. Many times youth must be transported hundreds of miles from home for inpatient treatment and then lack the aftercare services needed to transition to outpatient, and follow-up treatment when returned home.

When writing a grant a few months ago, I worked with Aberdeen Area IHS Behavioral Health staff to determine the ratio of mental health providers to AI population in the Aberdeen Area. The results were overwhelming: one psychiatrist per every 250,000 American Indians; one psychologist per every 17,000 American Indians; and one social worker or counselor per every 3,300 American Indians. Every county with AI reservations has been designated as Mental Health Professional Underserved Areas through the Health Resources and Services Administration (HRSA, 2008). The requirements for Mental Health Provider Shortage designations are 30,000: 1 for geographic areas or 20,000:1 for high need areas. Core mental health providers (CMHP; clinical social workers, psychiatric nurse specialists, clinical psychologists, and marriage and family therapists) rations 9,000:1 including psychia-

trists or 6,000:1 CHMP and 20,000:1 for psychiatrists (HRSA, 2009). Indian Health Services behavioral health services are currently funded at about 25% of the actual need. Solutions to this problem includes passage of the Indian Health Care Improvement Act, increased funding for behavioral health services to AI/AN communities, minimal standards for providers of behavioral health services to ensure the protection of those receiving services, funding for training programs to increase the numbers of AI/AN behavioral health service providers, cultural competence training for providers of health, and behavioral health services in AI/AN communities. Resources to utilize American Indians into Psychology trainees and other trained, credentialed, AI/AN providers on an emergency basis help to assist with suicide emergency situations. Many of the youth involved in suicidal behaviors are in need of substance abuse services as well as mental health services. More funding for dual diagnosis services close to home for these youth are important in maintaining connection with families and receiving care for both issues at the same time.

Education/Training

The need for training includes increasing the numbers of AI/AN licensed mental health providers and trainings on cultural awareness, competence, and integration into services, prevention, and programs provided for AI/AN youth. There are approximately 250 AI/AN clinically trained psychologists (0.3% of 84,883), 865 AI/AN clinically trained counselors (0.5% of 100,533), and 150 school psychologists (0.4% of 37,893) in the U.S. (SAMHSA, 2004). Currently, there are American Indian/Alaska Native into Psychology programs at the University of North Dakota, Oklahoma State University, the University of Montana, and the University of Alaska–Fairbanks. Utah State University has an unfunded American Indian Support Project. While these programs increase the number of AI/AN psychologists, there is a great need for more. The inclusion of clinical, counseling and school psychology programs would increase numbers and fill varied roles for mental health providers who receive the same licensure in states. To fill the gaps in the pipeline, mentoring programs to support AI/AN students between undergraduate and graduate programs would increase their competitiveness in applying to graduate programs and pre-doctoral internship programs; post-doctoral (pre-licensure) opportunities would provide clinical experiences with AI/AN clients and give those graduates work opportunities, helping them to get through the licensure process so they can work at IHS and tribal facilities.

In addition to training mental health providers, cultural competence and awareness training needs to be a requirement for all health service providers in Indian Country. It is critically important that those providing services can relate to the cultural values of the people they serve to increase the likelihood of AI/AN people in need of services seeking out the help that is available. If culturally appropriate programs, media, and services are not available, the resources are less likely to be used by those who need them most. In addition, a strong cultural identity has been found to be protective against depression (Gray, et. al, 2008).

While the need for services and well-trained professionals is evident, another area of need is the training of community members, first responders, and school personnel to recognize, assist, and support youth prior to reaching a suicidal state. Programs such as Question, Persuade, Refer (QPR) (Quinette, 1999) have been adapted for Indian Country and focus on suicidal behavior recognition and intervention. Mental Health First Aid is a program like a first aid program focused more generally on mental health issues, recognizing symptoms, crisis situations, intervening in a crisis, and supporting a person throughout any treatment or follow-up (MHFA, *http://www.thenationalcouncil.org/cs/press*__public/mental__health__first__aid__2/about__the__program/mhfa__course__description). This program has shown increased willingness for participants to intervene in the case of a mental health emergency, greater feelings of confidence in their abilities to do something in a mental health emergency, and reduced stigma regarding mental health issues by those completing the training *(http://www.mhfa.com.au).* Funding for programs like this in Indian Country, where there are great distances to travel for services and need for support locally, can help to increase capacity for supporting those in crisis within the community.

Research

Although we hear a great deal about evidence-based practices, there is virtually no research on evidence-based treatment with AI/AN populations (Miranda, et. al, 2005) and only two suicide prevention programs being studied to establish their efficacy: American Indian Life Skills and Sources of Strength (LaFromboise, 1996; LoMurray, 1998). There is very limited research on the assessments used to measure effectiveness of programs with AI/AN programs. These measures must be tested

before the results of efficacy of programs that utilize them can be tested to provide accurate information on the use of programs with AI/AN populations. To give the needed attention to this work, funds through NIMH, NIDA, and NIAAA are needed to address levels of research to measure, and provide evidence-based practices in AI/AN populations. Interfaced data and a national registry through IHS for suicidal behaviors and treatment, to provide data informing continuity of care across systems for inpatient, outpatient, dual diagnosis, and other supportive services, is necessary. Establishing a mandatory reporting system, such as the kind used for reporting child abuse, could help to identify troubled youth before they actually attempt suicide and subsequently get them access to prevention services.

Technology/Infrastructure

In remote areas of Alaska and throughout Indian Country, a technology infrastructure is needed, from electronic health records (EHR) that interface across IHS, tribal, Veterans Affairs, private, and public health systems, to telemental health programs that allow for services and billing of psychiatric and mental health services across state lines and licensure jurisdictions. Blue ribbon panels to address the issues of access across service systems of EHRs, and funds to support the development of the interface of these systems, are needed. Demonstration projects in telemental health are needed to find how these systems can provide better care and address the issues of licensure and access to services across state lines. Infrastructure funding is needed to provide adequate technological support for the distance services, including video and audio connections for youth located in residential treatment facilities to their families at home who may not be able to visit them while they are in treatment. This helps to maintain their connection to family and loved ones during a stressful time in their lives.

Summary

In summary, my recommendations to this committee cover four general areas: mental health services, education and training, research, and technology and infrastructure.

Mental Health Services

1. Passage of the Indian Health Care Improvement Act;

2. Increase funding to Indian Health Service to increased the number of credentialed mental health professionals providing services in Indian Country;

3. Increase funding of Indians into Psychology and Indians into Medicine to increase the numbers of AI/AN providers in Indian Country;

4. Increase funding of loan repayment programs to recruit and retain qualified mental health service providers in Indian Country; and

5. Fund aftercare treatment programs and circle-of-care services for transition and follow-up treatment for AI/AN youth.

Education and Training

1. Fund and require cultural competence training for service providers in Indian Country;

2. Increase funding and scope of Indians into Psychology and Indians into Medicine programs to more locations and include clinical, counseling and school psychology programs as part of Indians into Psychology;

3. Fund enrichment programs for AI/AN students between undergraduate and graduate programs to make them stronger applicants for graduate and medical school;

4. Fund clinical placement, internship, and post-doctoral residency programs for AI/AN students for experiences working with clients in Indian Country, and jobs in transition while working toward licensure; and

5. Provide funding for programs such as Mental Health First Aid that help to build community capacity and reduce stigma related to mental health issues and crises.

Research

1. Funding for research on assessment materials used to determine efficacy of treatment programs with AI/AN populations;

2. Funding for research to determine evidence-based treatments for AI/AN populations;

3. Promote and fund the interface of data and a national registry through IHS for suicidal behaviors and treatment, to provide data informing continuity of care

across systems for inpatient, outpatient, dual diagnosis, and other supportive services; and

4. Establish a mandatory reporting system to gather data, plan programming, and get youth needed services before they complete a suicide.

Technology/Infrastructure

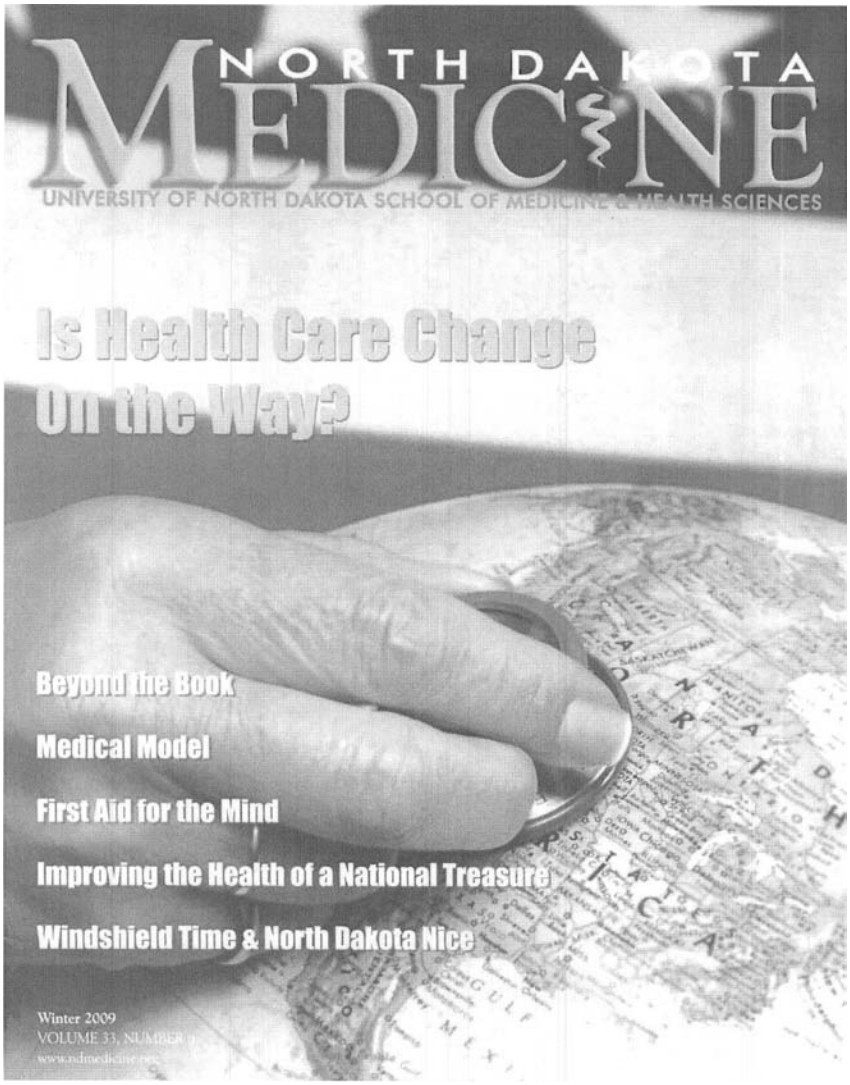
1. Fund interfacing of electronic health records across IHS, tribal, Veterans Affairs, private, and public health care systems;

2. Establish a blue ribbon panel to address the issues of access across service systems, as well as technology-based services across state lines, and licensure issues;

3. Fund demonstration projects in telemental health to find how these systems can be of greatest assistance in Indian Country; and

4. Fund infrastructure to connect service providers, families, and patients for communication and treatment planning with support networks while in residential treatment.

Attachment


NORTH DAKOTA
MEDICINE
UNIVERSITY OF NORTH DAKOTA SCHOOL OF MEDICINE & HEALTH SCIENCES
Is Health Care Change On the Way?
Beyond the Book
Medical Model
First Aid for the Mind
Improving the Health of a National Treasure
Windshield Time & North Dakota Nice
Winter 2009
VOLUME 33, NUMBER

First Aid FOR THE Mind

Healing the mind is as important as healing the body

JUST AS THERE ARE FIRST RESPONDERS trained to quickly deal with physical injuries during emergencies, **Jacque Gray, PhD**, teaches people to administer mental health first aid.

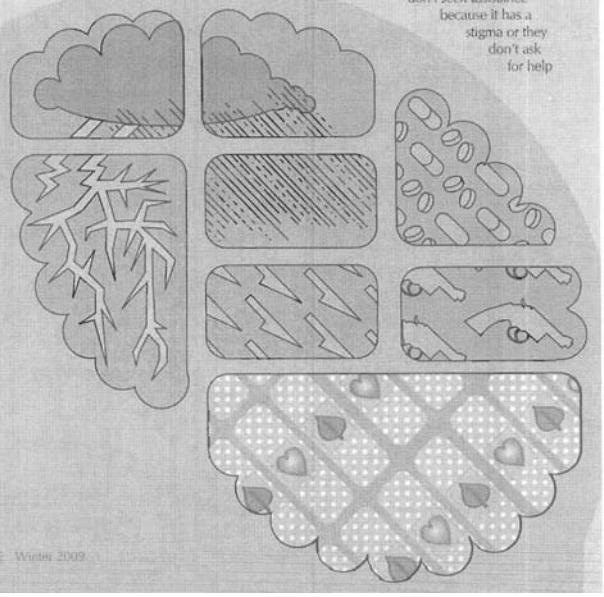
The concept, which originated in Australia, trains people to recognize mental health disorders and provide initial assistance for resources and professional help.

"You're not going to have someone trained in mental health first aid doing therapy or serving as a counselor," Gray said. "It's teaching them how to recognize the signs and then get the person in for help."

Having worked in the field of suicide prevention for 25 years, Gray, an assistant professor with the UND Center for Rural Health at the School of Medicine and Health Sciences, sees mental health first aid as another step toward combating the negative stigma often attached to treating mental health problems.

"What the Australians found with their research in rural areas is that the people who have gone through the training feel more confident and competent in being able to talk to someone they think may have a mental health issue," Gray explained. "It reduces the stigma about mental health.

"A lot of times, people don't seek assistance because it has a stigma or they don't ask for help



because, especially with our culture in the Northern Plains, it's like saying 'I'm weak and I need help,'" she said.

"The cultures that settled here were very independent, on their own and took care of themselves," she continued. "We take care of ourselves. We don't go outside of our family. We don't talk about certain things. Those types of beliefs are part of that culture in a lot of rural frontier areas."

According to the Centers for Disease Control (CDC), more than 32,000 Americans committed suicide in 2005, which made it the eleventh leading cause of death in the United States for all ages. Among American Indians and Alaska Natives ages 15-34, the CDC says suicide is the second leading cause of death.

Gray, a native of Oklahoma who's of Choctaw and Cherokee descent, came to UND in 1999 and joined the Center for Rural Health in 2004 to work on rural and Native mental health issues. She received a campus suicide prevention grant for American Indian students. Working with tribal leaders and state legislators led to broader efforts involving statewide community-based suicide prevention programs.

"When we wrote up the policy brief on suicide in North Dakota, we noted that out of the 800 suicides in the state over a ten-year period, over 700 of them were non-Indian," Gray said. "This is a North Dakota problem, not just an American Indian problem."

Gray recites a list of organizations, projects and grants in which she's involved in the area of suicide prevention, as well as research aimed at gathering data to define problems and determine which practices are most effective. She says it's a multifaceted approach.

"Part of it is working with a lot of the same people in these various projects and interfacing with them," she explained. "We're developing the capacity to prevent suicides and to help people become more resilient, healthier, having more success and feeling positive about what they're doing, as opposed to being so distraught and hopeless that they not only entertain suicide, but attempt to complete it."

A program funded by the North Dakota IDeA Network of Biomedical Research (INBRE) – administered by the medical school – is a good example of this approach. At Cankdeska Cikana Community College on the Spirit Lake Reservation, Gray and **Leander "Russ" McDonald, PhD**, former director for the National Resource Center on Native American Aging, are engaged in teaching students about the basics of research.

Jacque Gray, PhD

Russ McDonald, PhD

Students at the college take courses, participate in projects and will eventually learn to write grants. The project ties in with a tribal suicide prevention program that includes cultural camps for youth and community members, education and training in intervention.

"There will be graduate students from clinical psychology placed in the community to help increase the amount of mental health services that are available, providing more access for people to get in for services," she said. "This approach comes at the problem from all directions."

The goal is to use the knowledge and experience gained at Spirit Lake to develop similar programs in conjunction with the other tribal colleges and communities across North Dakota. Research to discover which practices work best and training to implement them will lead to more effective suicide prevention programs.

Part of intervening with someone who's suicidal is to talk about exploring other options ... **they want that emotional pain they're feeling to stop.**

"Part of intervening with someone who's suicidal is to talk about exploring other options because they're only seeing that one," Gray said. "It isn't that they want to die, it's that they want that emotional pain they're feeling to stop."

Providing mental health first aid is the first step toward stopping the pain.

- Patrick C. Miller

PREPARED STATEMENT OF CORA WHITEMAN TIGER

JAMI'S MESSAGE

January 8, 1994 – November 3, 2008

Jami Rose Jetty
God has seen you struggling,
God says it's over.

On November 3rd, 2008 my youngest daughter Jami Rose Jetty, 14 years old ended her life by suicide. A beautiful young typical teenager that enjoyed being around her friends and cared deeply about their life problems. We will never know why she ended her life this way, but the messages we are receiving from her brings comfort to the family as we deal with her loss.

On November 12, 2008 the Cankdeska Cikana (Little Hoop) Community College invited the Spirit Lake community to a *"Suicide Prevention from a Lakota Perspective, The Wiping of Tears Ceremony for all who need healing"* with Rick & Ethleen Two Dogs from Pine Ridge, South Dakota. Dana, James-Jami's dad, Louie-her older brother, Alex-Dana's boyfriend, Aaron-Jami's boyfriend and I attended this event.

During this ceremony I mentioned to Rick and Ethleen that I wanted to know where my daughter was. Ethleen said we will talk after the ceremony was over, then Rick mentioned to everyone in attendance that my daughters' spirit was there. I felt so relieved and happy just knowing that she was in the room with us. After this ceremony I spoke to Rick and Ethleen. They told us to bring Jami's favorite food, what she liked to eat and drink to the sweat that evening that they will bring her into the sweat so we can talk to her.

Later that evening we attended the sweat – Inipi (Purification Lodge Ceremony). In the sweat after the 2nd round of singing and praying the others left the sweat lodge and four family members remained James, Louie, Aaron, and I with Rick and Ethleen.

During sweats and ceremonies Ethleen has to translate for Rick when his medicine men/doctors from the spirit world are present. Ethleen said that Rick had to go up on a hill to pray before he came to the sweat. There was an old grave on the hill, and the spirit from that grave was going to bring Jami into the sweat. After Rick sang, Jami and the spirit from that grave came in and were sitting at the entrance of the sweat. Again, I was happy and not feeling any sadness.

We all got to talk to Jami one at a time. I won't go into detail. Jami gave us several messages: ***That she didn't mean to do this. (Then she had us listen and let her know what we hear, we all heard humming along with the rain drops on the canvas.) She said there are lost souls walking around crying, they did the same thing she did, and to pray for them, because no one did what you are doing for me right now***

for them. And tell the ones that are trying to end their lives this way; it's not the way to go, it's really scary. And that she will come to one of us in our dream.

On November 15th my cousin came to my house. He said he didn't know my daughters that well, but he had a dream the other night of the one that passed away. She said, ***"Tell my mom and dad that I am OK, I'll be over here for awhile but I am OK. I was really scared I even went to my Auntie Catalina's two times."*** My cousin didn't know we were expecting her to come to one of us in our dreams. I was comforted by this information.

On November 24th I received a call from Pastor Dave from the Bethel Evangelical Free Church in Devils Lake. He wanted to express his sympathy and that he met Jami just briefly on November 2nd when she attended their church. We talked some then hung up. (Jami also attended church the evening of November 2nd in Tokio.)

On November 25th, I received a letter from Pastor Bruce from the above mentioned church (attached). The date on the letter is Monday, November 24, 2008 (my birthday). This is my birthday card from Jami. (Note: I did call the church and asked if they knew that Monday was my birthday, they didn't.)

I will never stop loving or thinking of my seedykins (my pet name for her from birth), she will always be in my heart and prayers. Please share with others. Thank You!

Mother of Jami Rose,

Cora Whiteman Tiger

BETHEL
EVANGELICAL FREE CHURCH

Monday, November 24, 2008

The Family of Jami Jetty
PO Box 562
Fort Totten, ND 58335

Dear Family,

Please allow me to express my deepest sympathies for your loss. I am pastor of Bethel Evangelical Free Church in Devils Lake and I had the opportunity to meet Jami just once and then just for a brief minute on Sunday, November 2. As you may know, Jami was here with one of her friends and some of her relatives who had invited her. As they all left that day, I was greeting people at the door as they were leaving and I just introduced myself and asked their names. It was a very brief encounter and one that I might quickly forget. But when I found out on Tuesday what had happened the day before, I just stopped in my tracks. Immediately questions began to fill my mind. How could this happen? What was going on that would lead her to make this kind of decision? Was she in our church for some reason that Sunday?

I probably will not know the answers to those questions in this life, but one day I trust God will make it all clear when we see Him. I wanted to share something with you. A week after Jami's death, the card that she had filled out the previous Sunday was found near the entrance of the church. We have little cards that guests (and anyone) can fill out, giving their contact information which lets us know how to get in touch with them, which is how I have your address. On the back of that card is a list of options to let the new person quickly tell us what they would like, such as whether they would like to talk to a pastor or get information on the church. I thought you might like to know that Jami had checked the box that said, *"I would like information on becoming a Christian."* But there was more. There is another set of options for them called *My Decision Today*. Jami had a check mark there too, in the box beside this comment: *"I am renewing my commitment to Christ."* I was absolutely stunned when I saw both of those. It told me that Jami did have a desire to know the Christ who had given his life in exchange for hers. I do not know what led her to that decision that day, but I find hope and comfort in the knowledge that she had a desire to know Christ in a more personal way.

I do not know your faith background, but I share this only for two reasons; first, it made a huge impact on me. It is a powerful reminder that every person is important – young or old, rich or poor, native or white or black or whatever ethnic origin. Every person is important to God and they should be to me too. I'm glad I met Jami that day. Second, I share it with you because perhaps you need hope these days too. We have a good and powerful Creator. The Bible says that God cares for each sparrow and He knows each hair on our heads. God loves Jami – I am absolutely convinced of that. And He loves you too. If there is anything that I or Pastor Dave can do – talk with you, visit you or anything else – we would like to let you know that we want to be available to you and for you. The church is supposed to be God's "family" and we want you to know that this "family" loves God and loves people. You are in my prayers.

Pastor Bruce Dick

Jeremiah 29:11-14

Dana Jetty

November 3, 2008

I was home because I was suspended from school for three days.

My sister Jami came home around 9:30 a.m. and woke me up to tell me she was feeling sick and dizzy and that if she threw up to call the ambulance. I asked her if she took anything and she said she did, but she didn't tell me what she took or how much. I called my Mom at work and told her what Jami had told me. Then she came home right away, she asked Jami what she took, but Jami got mad and said nothing. At this time Jami was sitting on the bathroom floor, my Mom was asking Jami questions. Jami got up, sat on the bed and told my mom to leave her alone and be a Mom. My Mom was trying to get Jami to go to the clinic but she refused, and said she'll be alright. My Mom called the school and asked the principal why he let Jami go from school. He said he didn't and Jami must have left on her own.

My mom told me to keep an eye on Jami because of the pills she took. My Mom left and Jamie got mad at me for calling my Mom.

Jami was in her room crying. I asked her what was wrong. She started to tell me that her boyfriend doesn't care anymore. So, I told her to forget about him, and she said she couldn't and that she cared a lot for him. Then she asked me to leave her alone, I hesitated at first then asked if she wanted me to leave. She said yes. All the while she was lying underneath the blankets. So, I left her room and went into the living room. I watched TV for a little bit then started cooking. After I ate I was going to start cleaning the house. I was going to ask Jami to do the dishes. I walked to the back of the house, where her room is and told her to do the dishes but she didn't respond. Then I noticed the bathroom light was on and the door was shut and so was her bedroom door. So, I opened the bathroom door and she wasn't in there. Then I opened her bedroom door.

I instantly got an overwhelming feeling of fear and shock as it didn't sink in to what I was seeing.

Jami was in a sitting position against the wall on her bed with a belt around her neck. The belt was tied to the bars of the top of her bunk bed which was leaning against the wall. I ran into the living room and told my boyfriend what Jami had done, then I ran back into Jami's room and he followed. I tried to take the belt off of her neck but it was too tight. Then my boyfriend cut her down. After that, I called my Mom and Dad. I sat there holding her till they came. I was crying uncontrollably talking to her asking her, "Why?"

I couldn't comprehend what had just happened. Then I heard my Mom and Dad come running in. My Dad started to do CPR on her, and my Mom was on the phone calling the Police Department to get the ambulance here. Then not even five minutes later they were here. The paramedic worked on her with no response, they did get a slight pulse at one time, and then they rushed her to the hospital.

She was already gone by the time they got there. The doctor at the hospital said if she would've survived she would have been brain dead.

The experience of losing my sister, best, friend, someone I confided in, is very painful and hard to accept. I feel lost, lonesome, alone, and sometimes angry because I don't know why she did this while I was just in the other room. We always told each other "everything". She didn't tell me how she felt. I know she thought that I had enough of my own problems and didn't want to burden me with hers, but she still could have told me.

It's been about two and a half months now and I still feel lost, lonesome, and alone, but what I have learned from this is; don't keep things to yourself, talk to someone because there is always someone there for you who is willing to listen and help you.

PREPARED STATEMENT OF JESSICA HAWKINS, PREVENTION PROGRAM MANAGER, OKLAHOMA DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

ODMHSAS Mission

To Promote Healthy Communities and Provide the Highest Quality Care to Enhance the Well-Being of all Oklahomans.

Oklahoma's Suicide Prevention Initiative

In 2005, Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) was awarded $1.2 million over 3 years by the Substance Abuse and Mental Health Services Administration (SAMHSA)—Center for Mental Health Services, through the Garrett Lee Smith Memorial Act, to implement youth suicide prevention programs across the state. Oklahoma proposed to utilize this grant funding to implement portions of the state plan on youth suicide prevention.

The Oklahoma State Plan on Youth Suicide Prevention was developed at the request of the Oklahoma Legislature. House Joint Resolution No. 1018, passed in 1999, created the Youth Suicide Prevention Task Force with the assignment of submitting recommendations to the Legislature on the prevention of youth suicide. This task force involved physicians, educators, survivors, mental health professionals, clergy, legislators and representatives from state agencies including Health, Mental Health and Substance Abuse Services, Education, and Juvenile Affairs. The Oklahoma Youth Suicide Prevention Council was formed in 2001 to implement the plan and also serves as the advisory body for implementation of the Garrett Lee Smith project.

Oklahoma's grant-funded youth suicide prevention initiative allocates funds for statewide, evidence-based suicide prevention strategies including gatekeeper training and screening. The grant funds five community-based projects, including one with the Kiowa Tribe of Oklahoma. Kiowa Tribe is located in Southwest Oklahoma. The tribe's suicide prevention project includes gatekeeper training (QPR), youth suicide risk screening (Columbia TeenScreen) within Riverside Indian School, suicide prevention themed Pow-Wow events, and youth leadership development. Also notable is that Indian Health Service is the major sponsor of the state's annual Suicide Prevention Conference and serves as an active participant on the state's Youth Suicide Prevention Council.

Notable accomplishments in Oklahoma regarding suicide prevention include:

2000: Oklahoma Legislature made suicide a reportable injury in 2000, leading to the current collection of hospital discharge data on suicide attempts.

2006: ODMHSAS initiated an important partnership with a large-scale hospital system in Central Oklahoma to train all physicians, nurses, and staff in suicide prevention. This effort has resulted in similar partnership with other large-scale hospital systems in the state.

2006–2008: ODMHSAS trained 3,125 people as suicide prevention gatekeepers (number for those completing evaluation surveys; actual number trained is estimated to be much higher) and 62 people as certified gatekeeper instructors.

2008: Oklahoma Legislature passed Senate Bill 2000 which expands the scope of the Oklahoma Youth Suicide Prevention Act from youth-specific to across the lifespan. In November 2008, the Youth Suicide Prevention Council will become the Oklahoma Suicide Prevention Council and will undertake the task of revising the state plan on suicide prevention to address all populations.

In Spring 2008, ODMHSAS reapplied to SAMHSA to continue the youth suicide prevention initiative an additional three years. The new grant would provide additional funding for the provision of suicide prevention among high risk youth populations, including those in the juvenile justice system, foster care, and mental health/substance abuse treatment.

Attachment

Summary of Reportable Injuries in Oklahoma

Fatal and Nonfatal Self-Inflicted Injuries in Oklahoma, 2002-2004

Ruth Azeredo, Dr. P.H.
Epidemiologist
Injury Prevention Service
Oklahoma State Department of Health

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Fatal & Nonfatal Self-Inflicted Injuries in Oklahoma, 2002-2004

Background

Statewide surveillance for fatal and nonfatal self-inflicted injuries was initiated in July 2001. Data on persons who were hospitalized for a self-inflicted injury were collected from medical records that had an external cause of injury code (E code) for a self-inflicted injury (E950-E959). Data were also collected from the Office of the Chief Medical Examiner on persons with suicide as their manner of death. This summary includes data on fatal and nonfatal self-inflicted injuries that occurred during 2002-2004. Information is presented on all self-inflicted injuries followed by data on fatal and nonfatal self-inflicted injuries separately to portray the differences in epidemiologic and other characteristics. Rates were calculated using 2002-2004 Census bridged-race data.

Table 1. Epidemiologic Characteristics of Fatal and Nonfatal Self-Inflicted Injuries, Oklahoma, 2002-2004

Characteristic	Number	Percent	Average Annual Rate per 100,000 Population
Age			
Range 8-99 Years			
Mean 36 years			
Median 35 years			
Age Group			
05-14	297	4%	20.7
15-24	1993	25%	124.8
25-34	1743	21%	125.7
35-44	1944	24%	130.8
45-54	1270	16%	87.4
55-64	476	6%	45.3
65+	389	4%	28.1
Gender			
Female	4348	54%	8.2
Male	3764	46%	7.3
Race			
White	6823	84%	78.2
Native American	574	7%	60.2
Black	517	6%	59.8
Asian	131	0%	17.2
Other/Unknown	167	3%	1.2
Marital Status			
Divorced	917	11%	
Married	2092	26%	
Separated	170	2%	
Single	3529	44%	
Widowed	160	2%	
Unknown	1244	15%	
Employed (16+ years of age)	1640	22%	15.6
Alcohol Involvement	1999	25%	19.0

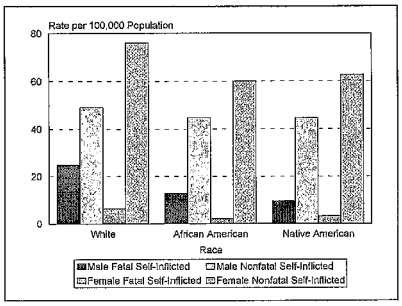
- 8112 self-inflicted injuries occurred from 2002-2004; 1483 (18%) died.
- The overall rate of injury was 76.8 per 100,000 population.
- Persons 15-44 years had the highest injury rates.
- The rate of injury was highest among whites and lowest among Asians.

Table 2. Primary Method of Fatal and Nonfatal Self-Inflicted Injuries, Oklahoma, 2002-2004

Characteristic	Number	Percent	Average Annual Rate per 100,000 Population
Primary Method of Injury			
Drowning	9	<1%	0.1
Fire	32	<1%	3.0
Gas/Poison	102	1%	1.0
Firearms	997	12%	9.5
Hanging/Strangulation	325	4%	3.1
Jump	38	<1%	0.4
Motor Vehicle	21	<1%	0.2
Solid/Liquid Poison	5781	71%	55.0
Stabbing	716	9%	6.8
Suffocation	4	<1%	0.1
Walk	3	<1%	0.1
Other/Unknown Method	84	3%	1.0

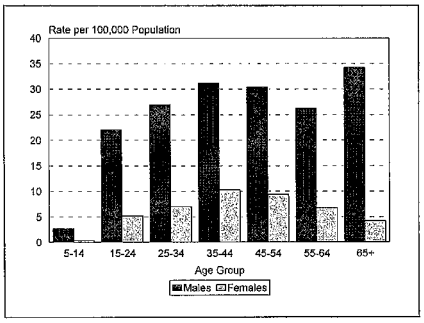
- The dominant method of injury was solid or liquid poisoning, used by 71% of all persons (rate 55.0 per 100,000 population).
- Firearms were the second leading method (12%) for all persons followed by stabbing (9%).

Figure 1. Rates of Fatal and Nonfatal Self-Inflicted Injuries by Race and Gender, Oklahoma, 2002-2004



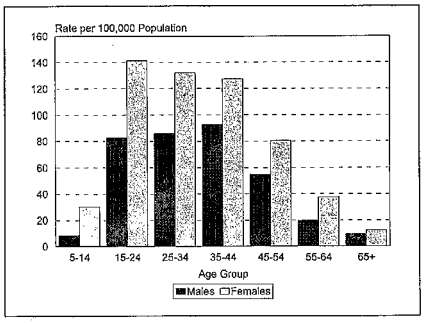
- The rate of fatal injuries was highest among white males (24.8), followed by African American (12.8) and Native American (9.6) males.
- The rate of nonfatal injuries was highest among white females (76.0), followed by Native American (62.7) and African American (60.0) females.
- The ratio of nonfatal to fatal injuries was 2.1:1 for males and 13.2:1 for females.
- White males and females had the highest rate of fatal and nonfatal injuries.

Figure 2. Fatal Self-Inflicted Injury Rates by Age Group and Gender, Oklahoma, 2002-2004



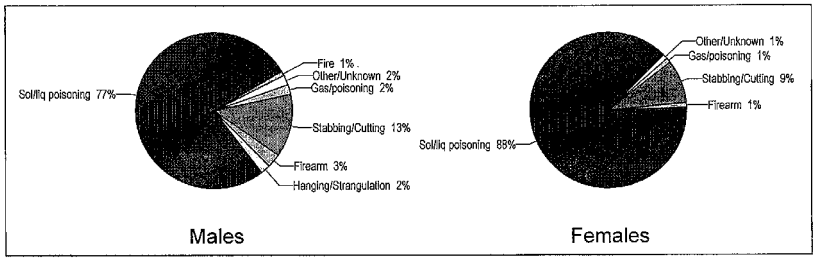
- Rates of fatal injury were higher among males, with male to female ratios ranging from 3:1 for persons aged 35-44 years to 8:1 for persons 65 years and older.
- The average age of persons with fatal injuries was 44 years, with a range of 9-93 years for males and 14-89 years for females.
- Fatal injury rates increased with age among males with a slight decrease at 45-64 years.
- Among females, fatal injury rates increased with age until 35-44 years and then declined.
- Rates were highest among males 65 years and older; among females, persons under 15 years and 65 years and older had the lowest rates.
- 80% of fatal injuries occurred among males.

Figure 3. Nonfatal Self-Inflicted Injury Rates by Age Group and Gender, Oklahoma, 2002-2004



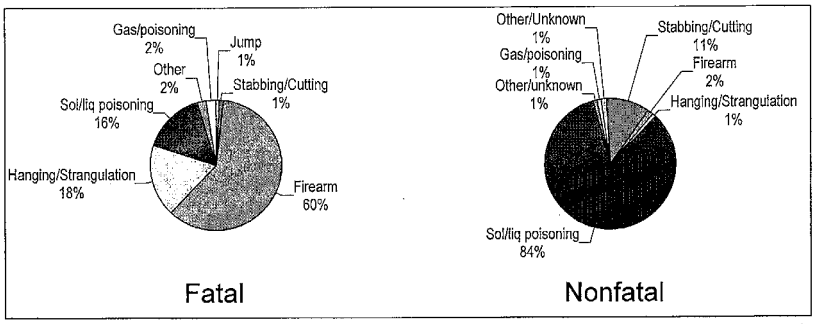
- Rates of nonfatal injury were higher among females, ranging from 12.5 among persons 65 years and older to 141.3 among persons 15-24 years.
- The average age of persons with a nonfatal injury was 34 years, ranging from 8-96 years for males and 9-99 years for females.
- Rates were highest for persons 15-44 years of age; rates for females declined after 24 years and males after 44 years.
- Rates were lowest for persons under 15 years and 65 years and older.
- 61% of nonfatal self-inflicted injuries were among females; the female rate was 76.0 compared to a rate of 50.0 for males.

Figure 4. Methods Used in Nonfatal Self-Inflicted Injuries by Gender, Oklahoma, 2002-2004



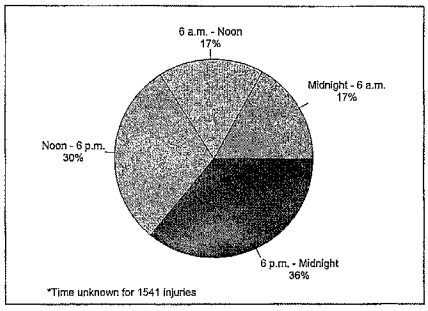
- The leading method used in nonfatal injury by females (88%) and males (77%) was solid and liquid poisoning.
- Firearms were used 3 times more by males than females.
- Stabbing was the second leading method used by both males and females.
- For persons who used two methods (3%), solid/liquid poisoning was the leading method accompanied by stabbing for males and females.
- Hanging or strangulation was used twice as often among males.

Figure 5. Methods Used in Fatal and Nonfatal Self-Inflicted Injuries, Oklahoma, 2002-2004



- A total of 6651 persons incurred a nonfatal self-inflicted injury and 1461 sustained a fatal injury during 2002-2004 (annual rates 13.6 and 60.7 per 100,000 population, respectively.
- The leading methods for fatal injury were firearms, hanging/strangulation, and poisoning.
- The leading methods for nonfatal self-inflicted injury were solid/liquid poisoning and stabbing.
- For each fatal self-inflicted injury there were 4.5 hospitalized nonfatal self-inflicted injuries.

Figure 6. Time When Nonfatal Self-Inflicted Injuries Occurred, Oklahoma, 2002-2004*



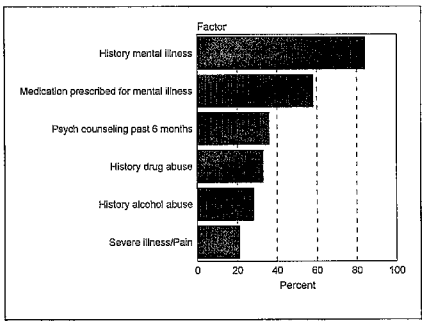
- The time of occurrence was known for 81% of nonfatal self-inflicted injuries.
- The lowest percentage of injuries occurred from midnight to noon.
- The highest percentage of injuries occurred between 6 p.m. and midnight.
- The time of nonfatal self-inflicted injuries was similar for males and females.

Table 3. Three Leading Methods of Fatal Self-Inflicted Injuries by Age Group, Oklahoma, 2002-2004

Age Group	Leading Method (%)	Second Leading Method (%)	Third Leading Method (%)
5-14	Hanging/Strangulation (55%)	Firearm (45%)	
15-24	Firearm (61%)	Hanging/Strangulation (23%)	Solid/liquid Poisoning (8%)
25-34	Firearm (55%)	Hanging/Strangulation (31%)	Solid/liquid Poisoning (11%)
35-44	Firearm (51%)	Solid/liquid Poisoning (24%)	Hanging/Strangulation (22%)
45-54	Firearm (56%)	Solid/liquid Poisoning (26%)	Hanging/Strangulation (13%)
55-64	Firearm (74%)	Solid/liquid Poisoning (20%)	Hanging/Strangulation (5%)
65+	Firearm (86%)	Hanging/Strangulation (7%)	Solid/liquid Poisoning (6%)
All age groups	Firearm (61%)	Hanging/Strangulation (14%)	Solid/liquid Poisoning (15%)

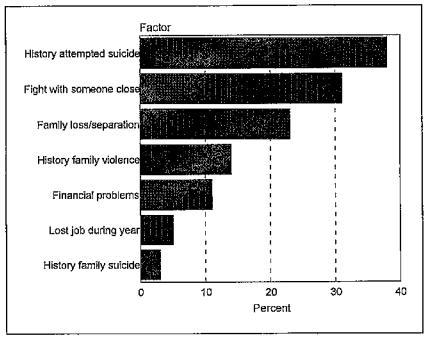
- Firearms were the leading method used in fatal injuries among all age groups except children aged 5-14 years.
- The second leading method used in fatal injuries was hanging/strangulation for persons 15-34 years of age and for persons 65 years and older.
- For persons 35-64 years of age, the second leading method of fatal injury was solid/liquid poisoning.
- Overall, firearms accounted for almost two-thirds of all fatal self-inflicted injuries.

Figure 7. Medical History Factors among Persons with a Nonfatal Self-Inflicted Injury, Oklahoma, 2002-2004



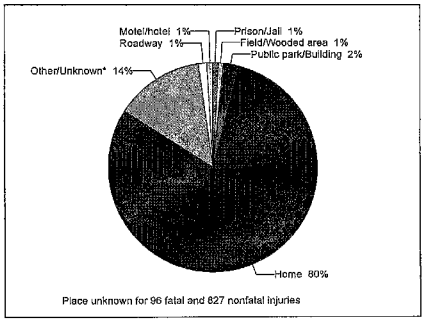
- 83% of persons with nonfatal self-inflicted injuries had a medical history of mental illness.
- 55% of persons had medication prescribed for mental illness.
- 36% of persons had received psychological/psychiatric counseling during the previous 6 months.
- A history of alcohol and drug use was reported among 28% and 33% of persons with nonfatal injuries, respectively.
- 21% of persons were suffering from a serious illness or pain.

Figure 8. Social/Psychological History Factors among Persons with a Nonfatal Self-Inflicted Injury, Oklahoma, 2002-2004



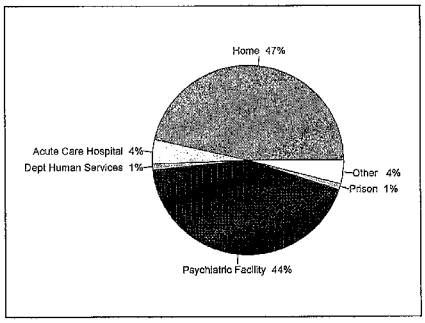
- 38% of persons had a history of nonfatal self-inflicted injury; 3% had a history of family suicide.
- Having a fight with someone close was a factor in 31% of nonfatal self-inflicted injuries.
- Financial problems or loss of a job were factors in 11% and 5% of nonfatal self-inflicted injuries, respectively.
- Loss or separation of a family member was a factor in 23% of nonfatal injuries.

Figure 9. Place of Fatal and Nonfatal Self-Inflicted Injuries, Oklahoma, 2002-2004



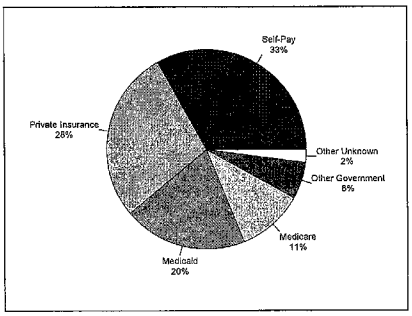
- The predominant location for fatal (80%) and nonfatal (80%) injuries was in and around the home.
- Public parks and buildings were the second leading location for self-inflicted injuries.
- The ratio of fatal to nonfatal injuries that occurred in fields and wooded areas was 5.4:1.
- The proportion of injuries for each place was similar among males and females, except for field/wooded area which was higher in males.

Figure 10. Nonfatal Self-Inflicted Injuries by Discharge Status, Oklahoma, 2002-2004



- Nearly half of persons with nonfatal self-inflicted injuries were discharged home and 44% were discharged to a psychiatric facility.
- Persons 65 years and older and 5-14 year olds had lower percentages of discharge to home (28% and 43% respectively).
- 4% of persons were discharged to another short-term hospital.
- 2% of persons left against medical advice; 1% were discharged to jail or prison.

Figure 11.Primary Methods of Hospital Payment for Persons with a Nonfatal Self-Inflicted Injury, Oklahoma, 2002-2004



- Self-pay was the predominant method of payment for nonfatal self-inflicted injuries.
- 28% of acute care stays were paid by private insurance.
- Medicaid (20%) and Medicare (11%) were the principal methods of government-funding; an additional 6% was paid by other government funds.
- Payment sources for persons discharged to home or to psychiatric facilities were similar.

Figure 12. Fatal and Nonfatal Self-Inflicted Injury Rates by County of Residence, Oklahoma, 2002-2004

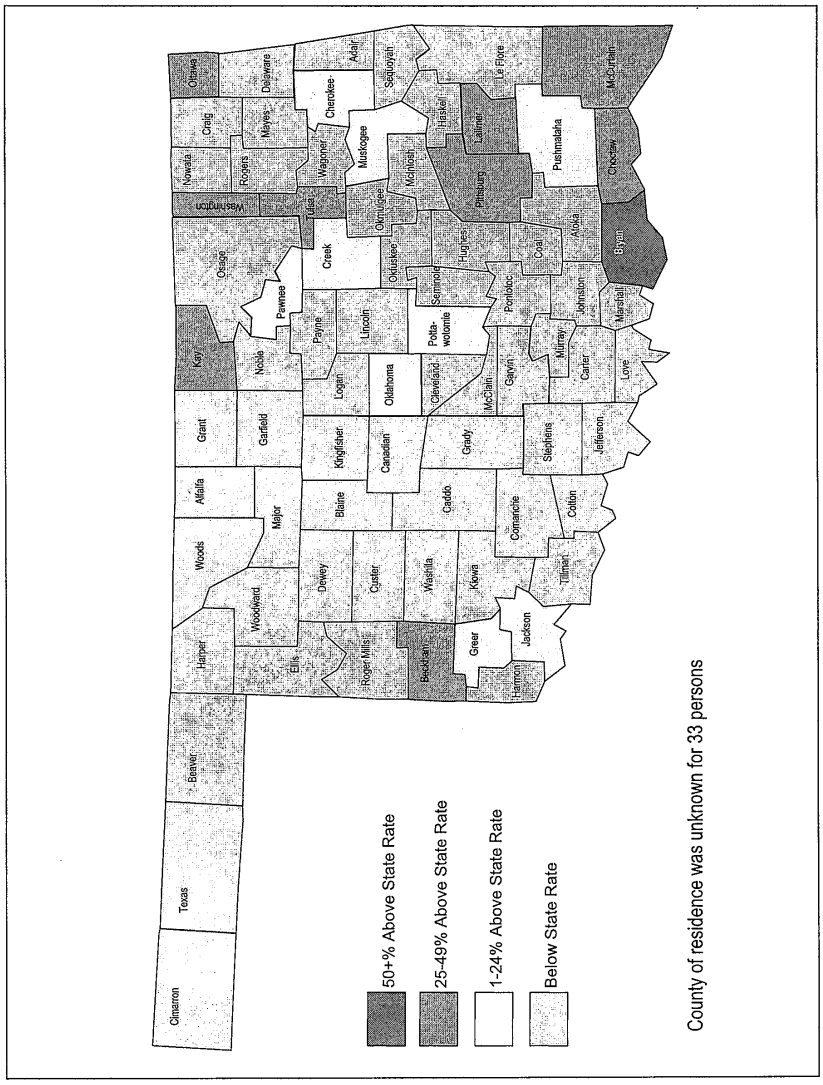


Table 4. Fatal and Nonfatal Self-Inflicted Injury Rates by County of Residence, Oklahoma, 2002-2004

County	Average Annual Population	Number of Cases 2002-2004	Average Annual Rate
Bryan	37,301	141	126.0
Beckham	19,548	67	114.3
Ottawa	32,795	112	113.8
Kay	47,224	159	112.2
Choctaw	15,390	47	101.8
McCurtain	34,093	104	101.7
Pittsburg	44,048	133	101.0
Washington	49,104	148	100.5
Tulsa	569,754	1,715	100.3
Latimer	10,583	31	97.6
Oklahoma	676,665	1,901	93.6
Jackson	27,278	75	91.7
Muskogee	70,326	192	91.0
Pawnee	16,853	46	91.0
Pushmataha	11,714	31	88.2
Cherokee	43,781	113	86.0
Pottawatomie	66,916	172	85.7
Creek	68,712	176	85.4
Greer	5,886	14	79.3
State of Oklahoma	**3,506,074**	**8,077**	**76.8**
Okmulgee	39,820	90	75.3
Lincoln	32,304	73	75.3
Sequoyah	40,080	88	73.2
Roger Mills	3,227	7	72.3
Pontotoc	34,949	75	71.5
Le Flore	48,891	104	70.9
Mayes	39,007	82	70.1
Carter	46,566	96	68.7
Murray	12,675	26	68.4
McIntosh	19,829	39	65.6
Garvin	27,239	52	63.6
Adair	21,528	41	63.5
Rogers	77,189	147	63.5
Craig	14,831	28	62.9
Seminole	24,592	46	62.4
Custer	25,178	47	62.2
Grady	47,470	88	61.8
Marshall	13,708	25	60.8
Comanche	110,858	201	60.4
Stephens	42,665	76	59.4
Wagoner	61,781	110	59.3
Payne	69,490	123	59.0
Haskell	11,978	21	58.4
Kingfisher	14,063	24	56.9
Caddo	30,082	50	55.4
Harmon	3,060	5	54.5
Okfuskee	11,657	19	54.3
Hughes	14,004	22	52.4
Osage	45,195	70	51.6
Johnston	10,461	16	51.0
Kiowa	9,949	15	50.3
Harper	3,412	5	48.8
McClain	28,595	41	47.8
Canadian	93,165	133	47.6
Atoka	14,141	20	47.1
Washita	11,407	16	46.8
Woods	8,669	12	46.1
Blaine	11,410	15	43.8
Cleveland	218,681	282	43.0
Ellis	3,968	5	42.0
Noble	11,266	14	41.4
Tillman	8,869	11	41.3
Logan	35,598	44	41.2
Nowata	10,749	13	40.3
Delaware	38,569	44	38.0
Garfield	57,212	64	37.3
Beaver	5,522	6	36.2
Dewey	4,615	5	36.1
Jefferson	6,510	6	30.7
Cotton	6,517	6	30.7
Texas	20,089	18	29.9
Coal	5,964	5	27.9
Grant	4,946	4	27.0
Cimarron	2,962	2	22.5
Major	7,441	5	22.4
Love	8,993	6	22.2
Woodward	18,624	10	17.9
Alfalfa	5,883	2	11.3

*Average annual rates per 100,000 population were computed using bridged-race population estimates summed for 3 years of data.
County of residence unknown for 35 persons.

PREPARED STATEMENT OF JO ANN KAUFFMAN, PRESIDENT, KAUFFMAN & ASSOCIATES, INC.

INTRODUCTION

Chairman Dorgan, Vice-Chairperson Murkowski, and members of the Committee, thank you for inviting me to submit written testimony on the topic of suicide among American Indian and Alaska Native (AI/AN) youth.

My name is Jo Ann Kauffman. I am the President of Kauffman & Associates, Inc. (KAI), a Native American woman-owned, SBA-certified 8(a), and HUBZone small disadvantaged business and GSA contractor. I am an enrolled member of the Nez Perce Tribe and earned a Masters of Public Health Administration from the University of California at Berkeley.

The mission of my company is to do work that matters to improve the health, education, and economic status of disadvantaged people, especially American Indians and Alaska Natives. We have been in business since 1990 and serve federal, state, local, and tribal governments with training, technical assistance, communications, event planning, information technology, research, evaluation, and other types of management support. We have offices in Spokane, WA and Silver Spring, MD, with additional employees stationed in Alaska, Arizona, Colorado, Michigan, and New Mexico.

In 2005, we were asked by the Substance Abuse and Mental Health Services Administration (SAMHSA) to develop an initiative which SAMHSA envisioned would prevent youth bullying, violence, and suicide in AI/AN communities. The Native Aspirations Project is a community engagement and mobilization program which supports evidence-based and culture-based interventions for tribal communities most at risk for youth bullying, violence, and suicide. The project was initiated by SAMHSA's Center for Mental Health Services (CMHS) and represents one of the more far-reaching, vigorous, and community-centered federal suicide prevention efforts in Indian Country today.

THE IMPACT OF SUICIDES IN INDIAN COUNTRY

Each year, more than 32,000 suicides occur in the U.S. This is the equivalent of 88 suicides per day or one suicide every 16 minutes. As the 11th leading cause of death in the U.S., more people die by suicide each year than by homicide. Nationally, suicide is the third leading cause of death among Americans between the ages of 15 to 24 and the second leading cause of death among those between the ages of 25 to 34.

The suicide rates for AI/ANs are even more alarming than for all Americans in general. In fact, recent available data show that suicide rates for American Indians are from 1½ to 3 times higher than the national average. Suicide is the second leading cause of death for American Indian youth between the ages of 15 to 24 -- 2½ times higher than the national average. During 1999-2005, the suicide rate among Alaska Natives was 3½ times that of the U.S. population, and suicide remains the leading cause of death for the 15- to 24-year-old age group of Alaska Natives.

The problems of youth violence and suicide are exacerbated by another insidious problem: youth bullying. Bullying is frequently an antecedent to violence and suicide. Statistics show that bullying is 1 of the 5 leading

causes of youth suicide. Bullying can have devastating effects on victims, as youth who are bullied generally show higher levels of insecurity, anxiety, depression, loneliness, unhappiness, and physical and mental symptoms. When youth are bullied on a regular basis, they may become despondent, suicidal, or homicidal. As one middle school student expressed, "There is another kind of violence, and that is violence by talking. It can leave you hurting more than a cut with a knife. It can leave you bruised inside." In our society today, violence and bullying are a deadly combination.

Addressing the serious issues of youth violence, bullying, and suicide can be daunting. In addition, communities that have recently experienced the loss of a young person to suicide often struggle to know how to respond to the tragedy and how to prevent this type of death from occurring again. When a young person commits suicide, it adversely affects the lives of at least six to eight other individuals and often leads to permanent consequences on the productivity, self-esteem, or physical and mental health of those individuals. Addressing these issues in Native communities requires public health and community interventions as much as clinical interventions

NATIVE ASPIRATIONS PROJECT

In 2005, following tragic incidences of violence and suicide among Native youth, SAMHSA issued a contract to KAI to work with SAMHSA in developing strategies to prevent similar events in other AI/AN communities. The purpose of Native Aspirations was and continues to be to decrease the risk factors that contribute to youth violence, bullying, and suicide and to increase the protective factors that are linked to the healthy and safe development of Native children and their families.

Native Aspirations is a first-of-its-kind project. The Native Aspirations approach is based on recognizing not only the challenges, but the unique strengths and cultural wisdom of tribal communities and Alaska Native villages. The initial community engagement requires the formal endorsement tribal governance and a community-wide event to share ownership of a prevention plan. Throughout the project, KAI staff provides individualized Training and Technical Assistance (TTA) to increase community collaboration and build capacity for planning, implementing, evaluating, and sustaining prevention efforts for Native youth. Currently, Native Aspirations is working with 25 communities and villages in three different cohorts (Cohort 1: 9 communities; Cohort 2: 7 communities; Cohort 3: 9 communities). Through a community selection process, another 40 communities have been identified (Cohorts 4-8) and will be invited to participate in the project through 2013.

The core element of Native Aspirations and the participating communities lies within the context of relationship, community, and culture, and is based upon the following principles.

- The solutions to AI/AN youth violence, bullying, and suicide must come from within the community and be owned, embraced, and actualized by the community.
- The leadership of the community must be involved and inverted in the solution.
- A clear, transparent project and evaluation framework of activities and expectations must be communicated to communities at the beginning and throughout the duration of the project.
- What works in one community may not be the same in another community, therefore we must be respectful and responsive to communities, honoring community-specific ways and preferences, cultural traditions and values, local governmental structures and leaders, and community pacing and challenges.
- Healthy and respectful relationships must be developed with the community at all levels, including with tribal leaders; Elders; service providers to youth and family, such as community counselors and school personnel; youth; and families in order to move the prevention efforts forward. In addition, respectful relationships must be put in practice within the KAI Team as well as with all other stakeholder groups such as SAMHSA, Garret Lee Smith (GLS) grantees, and subcontractors.
- Everything in the Native Aspirations story is of value and has something to offer each of the communities, KAI, SAMHSA, and other interested entities. We must learn together and use this

information wisely to better assist Native communities with their prevention efforts.

COMMUNITY STRATEGIES AND PREVENTION EFFORTS

In response to the high rates of youth suicide and violence, many Native Aspirations communities began implementing programs or grassroots efforts to address these issues prior to becoming engaged with the project. Some of these efforts were not specifically organized around suicide prevention, but focused on the creation of prevention councils, coalitions (e.g., increased collaborations between juvenile court and detention centers, drug and alcohol programs, mental health services, churches, and tribal police); centers and programs that provided services to young people (e.g., after school or summer programs, boys and girls clubs, boxing clubs, teen pregnancy and abstinence, truancy and dropout diversion); educational and outreach activities (e.g., awareness-building around suicide and violence, stigma-reduction campaigns); forming or strengthening partnerships between state and/or local entities and the tribal community; and accessing trainings for community members and service providers on gate-keeper strategies (e.g., Question, Persuade, and Refer [QPR]). Some communities were engaged in the development or implementation of culturally specific models to address problems confronting young people, including cultural and language revitalization projects; storytelling and cultural exchange; and Elder-youth mentorship programs. For example, one Alaska village implemented a program involving a Native storyteller and actor who provided cultural role modeling by using storytelling to teach values and principles as well as pride of heritage to young people.

Prior to their engagement with Native Aspirations, at least five communities were already working with the Montana-Wyoming Tribal Leaders Council Planting the Seeds of Hope project. Two communities were specifically working to address the problem of methamphetamine, and several others were scaling up efforts to address alcohol and drug use among young people. One community in particular had implemented a peer-based model, called "Peers Helping Peers," that operated on a very small level even after its funding was lost. An Alaska Native village had previously been working with local researchers at the University of Alaska Fairbanks on a suicide prevention project, "Towards Health Project."

In the Native Aspirations project, the community engagement events lead to the development of the Community Prevention Plan (CPP). This plan describes a community's specific approach to addressing youth violence, bullying, and suicide and connects short-term strategies with long-term outcomes. Upon review of the CPPs that were developed by the participating communities for the project, the following themes were found and are listed in order of the frequency of their inclusion within the community plans.

- **Awareness of Signs of Violence, Bullying, and Suicide.** All communities included activities that would raise awareness of signs of violence, bullying, and suicide through hosting speakers, providing educational workshops, conducting poster contests, hosting wellness and behavioral camps for youth, and conducting media campaigns.
- **Wellness Achieved Through Cultural Knowledge and Values.** Each participating community emphasized the need to provide education and awareness of culture through either culture camps, teaching of singing and dancing, teaching of traditional values, developing youth councils, and conducting media campaigns. The provision of cultural knowledge is defined as a culture-based intervention.
- **Coordination of Prevention Efforts.** Communities addressed the need for funds to provide for a local prevention coordinator position. The local Lead Contacts for the tribes are generally those with a full-time job, and the work associated with Native Aspirations is, for most, yet another responsibility.
- **Evidence-Based Interventions (EBI).** The participating communities identified specific EBIs within their respective CPPs. The EBIs that have been selected and are being implemented include: Positive Action, Second Step, Reconnecting Youth, Native Helping Our People Endure (HOPE), QPR, Project Venture, Gathering of Native Americans (GONA), Applied Suicide Intervention Skills Training (ASIST), and American Indian Life Skills Development Curriculum (AILSDC).

With the implementation of the CPPs, community progress was by identifying the following: (1) barriers to implementation; (2) successes in implementation; (3) TTA needs/requests; and (4) next steps, which are highlighted in Table 1 below.

Table 1. Community Prevention Plan Implementation Progress

Barriers to Implementation	• Limited participation of Oversight Panel members for the project • Not enough key individuals available or willing to help with prevention efforts • Difficulties in accessing and sharing data to provide follow-up to high-risk individuals • Not enough community resources to respond to the many needs • No after-hours crisis services available to suicidal individuals on the reservation • Geographic isolation and remoteness • Lack of transportation and long driving distances • Lack of skilled grant writers • Lack of trained staff • Lack of ongoing funding for prevention programs
Successes in Implementation	• Improvement in the team approach and processes • More people trained as gatekeepers in communities • More activities for youth • Elders involved with the youth • Increased suicide prevention awareness and knowledge • Partnerships created in the communities • More agencies/programs providing outreach services • Additional resources being identified • Fewer suicides reported • Training and implementation of evidence-based, practice-based, and culture-based (EBI/PBI/CBI) interventions • Cultural revitalization efforts • Tribal leaders becoming more aware and involved in suicide prevention at the local, national, and international level
TTA Needs/Requests	• American Indian Life Skills Development Curriculum, ASIST, QPR Gatekeeper, and Project Venture Training • GONA Training • Native HOPE Training • Budget management and grant writing • Critical incident stress management • Violence and bullying prevention training • Community healing and grief and loss • Historical and intergenerational trauma
Next Steps	• Promote youth councils • Recruit new members to serve on the Oversight Panel • Begin Elder/Youth collaborations • Recruit and hire Volunteers in Service to America (VISTA) workers to assist with CPP activities • Put up billboards for suicide prevention • Conduct youth camps • Strengthen families and protective factors through increased cultural activities • Identify expert consultants/trainers to help community healing efforts

OVERVIEW OF SUCCESSES

Although Native Aspirations communities are very geographically, economically, socially, and culturally diverse, what unites them are both the tremendous adversity they face in protecting and caring for their youth, and the tenacity with which they meet this challenge. It has become clear that the innate social, cultural, and traditional strengths and values that are the cornerstone of these communities are critical tools from which they draw upon when confronting the problems of youth violence, bullying, and suicide. Through the collaborative efforts of participating communities, SAMHSA and the Native Aspirations Project can report a number of successes as a result of engagement with tribes in this groundbreaking program. Some of these successes include:

- Empowering four communities to apply and receive Garrett Lee Smith suicide prevention grant funding from SAMHSA, which provides funding for programs to combat suicide;
- Creating, evaluating, and improving referral and resource systems and manuals for youth in crisis;
- Increasing awareness of the signs and symptoms of youth violence, bullying, and suicide and reducing the stigma of mental illness and other issues related to youth suicide through DVDs and other media campaigns;
- Providing community education and training at wellness conferences or symposia and other gatherings;
- Identifying and implementing tools for screening at-risk youth in schools and other youth programs;
- Creating crisis telephone lines, critical incident response plans, "suicide watch" protocols, and other community-wide support mechanisms (e.g., suicide prevention councils, teams, and task forces);
- Increasing collaboration through Memoranda of Understanding (MOUs) and other formalized agreements within and between agencies and programs that interface with young people (e.g., juvenile court, detention and diversion programs) both on and off the reservation;
- Creating state-wide tribal coalitions to share resources and knowledge and to focus efforts around planning; and
- Creating or increasing visibility of structured activities for young people (e.g., youth camps, Boys & Girls Clubs).

Clearly, what emerged from the community engagement processes of Native Aspirations are successes that have been founded upon social, cultural, and spiritual strength that remains in these communities, By identifying and drawing upon communities' innate resources, talents, and values, a phenomenal testament to their ancestral beginnings and the precious inheritance of their young is demonstrated.

OVERVIEW OF NEEDS

With poverty levels of half of the participating communities above 35%, the Native Aspirations communities are confronted with serious economic hardship and other social factors that make the prevention efforts in their local community much more difficult. All of the participating communities in Cohorts 1, 2, and 3 had unemployment rates that were significantly higher than the national average (in most cases between 3 to 10 times greater), ranging from a low of 12% to a high of 87%. Nine of the communities had unemployment rates of 50% and higher, while another seven had rates between 20% and 49%. The per capita income for the communities ranged from $5,200 to $14,661, with the majority of communities (18) having a per capita income of less than $10,000. The communities ranged in size from very small to extremely large: an Alaska village of 255 members to a Plains tribe with a population of 23,250. Six of the communities had populations smaller than 1,000 people, with five of them being Alaska Native villages. Another 11 communities had population sizes ranging from 1,000 to 9,999 people, with the remaining five communities having more than 10,000 people (these being primarily plains tribal communities).

Several of the communities are very small and remote. For example, five of the Alaska Native villages are in remote or interior parts of Alaska, and fairly inaccessible from the outside. Moreover, they are subsistence communities, with the bulk of their hunting, fishing, and other subsistence activities taking place primarily in

the spring and summer months when the days are longer and light is plentiful. One of the Southwest communities is located at the bottom of a canyon and only accessible by foot, pack mule, or helicopter. Other communities are tremendously large, covering huge land bases that span millions of acres over mountainous terrain in Montana and Wyoming or vast and remote areas in the South Dakota and western Montana plains. For instance, the Blackfeet and Cheyenne River communities are each about 1.5 million acres and Wind River and Crow reservations span 2.3 million acres, while Pine Ridge is the largest at nearly 3 million acres. These geographic realities make community planning efforts and the provision of technical assistance a significant challenge.

Furthermore, at least three of the communities are made up of two or more tribes sharing the same reservation land, and ten of the communities are made up of between 2 to 20 districts, which present significant challenges culturally, linguistically, and politically. At least two of the tribes have been relocated to reservation lands that are not at all ancestral (e.g., tribes that are historically woodlands people who are now living on the plains).

These economic and social conditions are the result of the historical oppression and forced relocation of nearly all of the communities, which resulted in physical and cultural genocide and cultural transformation. Nearly all of the communities are seriously affected by the historical and intergenerational trauma that is the legacy of westward expansion and manifest destiny. These abuses contribute significantly to the social and health problems that are plaguing each of the communities: There are tremendously high rates of alcohol and drug use; family violence and trauma; educational dropout and underachievement; poverty; and the loss of cultural and traditional life ways.

While almost all the Native Aspirations communities, with the exception of one or two, had either previously implemented or were actively making some efforts to address the problem of youth violence, bullying, and suicide at the time of engagement with the project, all were confronted with too little resources (e.g., lack of funding, dedicated staff, transportation, support services). In addition, many had either little to no behavioral health services readily available or there existed a serious fragmentation or duplication in services, which significantly and negatively affected their capacity to realize sustained efforts over time.

Isolation and lack of resources, including little or no funding for dedicated or full-time staff for prevention efforts; transportation; daycare; housing; education; and space to house prevention programs and activities, are typical of the communities. Lack of trust between individuals, families, and various stakeholders due to conflicts, old wounds, and deeply entrenched alliances has led to a failure to collaborate within and across programs and departments. Tribal elections and changes in tribal leadership can prevent or stall community progress and tribal councils are overburdened with other demands. As a result, attention to youth violence, bullying, and suicide and prevention services can become lost due to the sheer magnitude of other community needs.

LESSONS LEARNED

Through the efforts of tribal communities and Alaska Native villages we have learned valuable lessons throughout the Native Aspirations journey. Beginning with our first contract, significant changes were implemented that have improved the project and our relationship with the tribal communities and Alaska Native villages. Cross-cutting lessons learned follow:

- **Each participating community is unique and requires a community-specific, culturally respectful, and time flexible approach.** This lesson was first identified in the first year and reaffirmed throughout the project. In order to better understand a community, more information should be gathered about the community regarding its culture, community and cultural protocols, governance, demographics, history, programs, resources, and seasonal activities, prior to visiting it. Communities partake in traditional activities and celebrations (e.g., Alaska subsistence hunting and fishing, American Indian pow-wows), are geographically located in remote and isolated settings, and

frequently have limited technological capacity. Thus, the project schedule must be flexible enough to adapt to these community-specific characteristics.

- **Communities require extensive training and technical assistance (TTA) to ensure the mobilization of their efforts.** Increased funding resources and more technical assistance to communities makes a difference at the community level. Mobilizing a community using a grassroots approach demands a depth and breadth of resources (e.g., people, organizational capacity, funding, facilities), and such resources have proven to be limited in the participating communities. Thus, TTA provision must be ongoing, steady, and abundant to help the Lead Contacts, community members, and community organizations move the mobilization efforts forward. In the earliest stages of Native Aspirations, several of the communities struggled with getting the project activities mobilized and with developing their CPPs. Native Aspirations team members have shared the need for more resources to be allocated at the front end of community engagement in order for communities to gain more momentum for their project activities.
- **Community engagement must be flexible.** The Native Aspirations team has found a multipronged, redundant system for engaging tribal communities improves the likelihood of receiving a timely response. Our approach to blend a formal letter, phone calls, emails, faxes, and on-site visits, while maintaining a culturally respectful relationship has been an important feature to the success of Native Aspirations. Moving from multiple contacts to a central point of contact is a critically important transition, which occurs when the tribal government formally endorses the effort. In addition, initial site visits may require more time on the ground to meet with tribal leadership, build trust, and let the community really get to know our team.
- **A safe place for grieving is crucial for healing.** A safe place for processing and healing generationally delayed and contemporary grief related to youth violence, bullying, and suicide prior to beginning the formal planning process is absolutely critical. This project has utilized the Gathering of Native Americans (GONA) curriculum to bring whole communities together to address these difficult issues in a safe, culturally appropriate and structured format. It is important to engage local support staff to be actively involved in the GONA planning and to provide ongoing support to the community during the difficult discussions related to youth violence. This helped to build local capacity and extend the healing beyond the 3 or 4 days of the GONA.
- **Community planning is more important than a community plan.** By experiencing an organized planning process, community capacity for planning begins to build. The utility of the plan, whether developed through Native Aspirations or one that existed prior to the project, is to bring the community stakeholders together to reinvigorate their efforts and provide a forum for feedback, assessment, accountability, strategic adjustments, and future visioning. Key events or budget allocations should be tied to community planning events that celebrate the planning process and not necessarily just a written plan. The key to success is the act of planning and revisiting the plan as a group. It is not the production of a document.
- **Initial funding can provide leverage for other resources.** The major resource going to communities through this project is in the form of training and technical assistance by Native Aspirations staff, consultants and providers of other models brought to community. The purpose is to transfer the knowledge and skills to local providers and helpers. A small amount of direct funding is provided to communities by the Native Aspirations to subsidize activities. When matched with the significant onsite training, technical assistance, and planning, these funds can provide critical leverage to bring additional resources to the table. Communities that use their Native Aspirations funds to help support a dedicated staff person are more likely to maintain mobilization efforts. Eliminating barriers to receiving funds will be important for future efforts to ensure tribes can hire the necessary personnel to fulfill each of the project steps and sustain community effort.
- **Onsite time is important for TTA.** Our Community Coordinators have found that being in the community is critical to effective provision of TTA and for sustaining community focus and engagement. Communities have identified ongoing needs for bullying prevention training, sustainability and grant writing workshops, and other training needs. The most effective training has

occurred within the communities. The project provided three regional trainings on American Indian Life Skills Development Curriculum (AILSC) and found that the community that hosted the event was more likely to sustain the effort than communities that traveled to the training. This is an important lesson for planning future regional training events.

- **Sustainability must be an ongoing theme throughout Native Aspirations.** Cohort 1 and 2 communities have been participating in the project for approximately 26 months and are in various stages of their mobilization efforts. With these nine early communities moving into Year 3 of the project, the need for sustainability has become evident. Sustainability must be introduced to participating communities and integrated throughout the project. Our communities see Native Aspirations as having the potential to have a more lasting impact, and we hope to accomplish that by working to sustain these efforts through additional funding and institutionalizing the efforts.
- **Staff working in communities are personally affected need support.** We have found that those who interface regularly with communities stricken with youth suicides and violence, are personally affected emotionally, physically, and spiritually as they provide support and technical assistance to community members. Multiple-day site visits or back-to-back community visits can be emotionally and physically impacting. Support must be provided to those working within communities on traumatic issues such as youth violence and youth suicide to prevent burn-out and turn-over.
- **Community-specific and tribally regulated methods for program and evaluation engagement must be heeded and followed.** Because each American Indian tribe and Alaska Native village is sovereign, they must be the decision-makers as to program evaluation. Some tribes and villages may require an MOU regarding project participation and project evaluation. These MOUs can clearly articulate the benefits of the project to the tribe, the roles and responsibilities of the parties, the expectations of the tribe, and the expectations of the contractor. A key principle to the success of Native Aspirations has been our team's high regard and respect for tribal governance. MOU or tribal resolution negotiations for programmatic and evaluation engagement with communities can take time, labor, and resources. However, these are value added steps in Native Aspirations and underscore the importance of honoring and respecting tribes and building collaborative, trusting relationships with tribal communities and Alaska Native villages.
- **Evidence-Based, Practice-Based and Culture-Based Approaches are all needed and important:** We have found that communities will consider and embrace a mix of strategies and approaches and do not want to be limited to only those evidence based approaches sanctioned by the National Registry of Evidence-based Programs and Practices (NREPP). The significance of NREPP status should not be the sole determinant for future funding of interventions. Practice-based and culture-based interventions that have worked within tribal traditions for generations can be powerful tools to intervene and prevent in youth violence, bullying and suicide.
- **Access to resources a major struggle.** Tribal communities and Alaska Native villages have few options available to them in terms of access to funding. Discretionary grants are very competitive, and these small and rural communities typically have a difficult time submitting grant applications that meet the level of sophistication and standards that other applicant communities are able to achieve. The communities served by Native Aspirations represent some of communities with the greatest need and often with the fewest resources dedicated to grant-writing and fund raising. The Native Aspirations effort does not require expert grant writers, but identifies community selection through a quantitative and qualitative analysis of the need for youth violence prevention. However, in order to sustain these efforts the Native Aspirations communities will need to compete for limited dollars for behavioral health.

CONCLUSION

SAMHSA's goal for Native Aspirations is for American Indian and Alaska Native youth to experience a healthy and safe life in community. This goal is being realized. The numbers of community events, trainings provided, and data collected in Native Aspirations cannot tell the human side of the story. Community

members do tell the story. A Native Aspirations tribal community member shared that there have been fewer attempts and no completed suicides since Native Aspirations has been in his community. When asked if the community really thinks that the project can be responsible for that, the resounding answer was "yes" because people now have permission to speak openly about suicide and youth violence. A member of another community said that Native Aspirations has helped to bring increased interest and funding for other community projects.

The challenge with any prevention project is that change can seem almost invisible and only becomes evident over time. Within Native Aspirations communities, time and resources are always a premium and communities experience competing demands. Progress can be slow because of the small numbers of people who are trying to make changes and the discouraging episodes of violence or community factionalism that can undermine progress. However, as a community leader from one Native Aspirations community said, "Don't be discouraged when things don't happen right away. It is like the ice breaking; the ice is just beginning to crack."

Over the past 3 ½ years, the Native Aspirations project has started to make a difference. It is exciting to see communities envisioning new approaches and willing to try different strategies that offer hope and build upon cultural strengths. Native Aspirations has helped to fuel that vision and hope and will continue to draw from the richness of communities' histories and cultures to address violence, bullying, and suicide in effective, culturally appropriate ways.

Thank you for the opportunity to provide you with this testimony.

NATIVE ASPIRATIONS

NATIVE YOUTH VIOLENCE, BULLYING, AND SUICIDE PREVENTION PROJECT

What is Native Aspirations?

Native Aspirations is a national training and technical assistance (TTA) project sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA) to work with American Indian and Alaska Native (AI/AN) communities to address youth violence, bullying, and suicide. In 2005, SAMHSA identified an alarming national trend towards youth violence, bullying, and suicide and contracted with Kauffman & Associates, Inc. (KAI), a Native-owned firm, to develop Native Aspirations to focus its efforts on these critical issues facing our youth today. The three major objectives of the Native Aspirations are:

(1) to provide proactive mental health assistance to children, youth, and their families living on tribal reservations, urban areas, and in Alaska Native villages;
(2) to decrease the risk factors that contribute to youth violence, bullying, and suicide; and
(3) to increase the protective factors that are linked to the healthy and safe development of AI/AN children and their families.

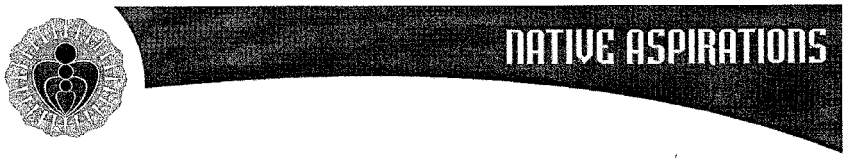
What is the Native Aspirations approach?

The Native Aspirations approach is based on recognizing the unique strengths and barriers of tribal communities and Alaska Native villages related to youth violence, bullying, and suicide prevention. Throughout the project, KAI staff provides individualized TTA to increase community collaboration and build capacity for planning, implementing, evaluating, and sustaining prevention efforts for Native youth. This is done through a supportive and progressive process between the community and the project in order to provide knowledge sharing and knowledge transfer.

How many Native Aspirations communities are there?

Currently, 25 AI/AN communities participate in Native Aspirations. Over the next 5 years, 40 additional communities will be added to the project for a total of 65 communities. The following map provides a geographic snapshot of the 25 current communities.

Our children are the songs of our future.



What can a participating community expect from Native Aspirations?
The Native Aspirations journey is a series of TTA and community planning events to help AI/AN communities build a community platform to mobilize prevention efforts, implement them, and sustain them. In addition, the community receives financial support to select and implement evidence-based, practice-based, and culture-based interventions (EBI/PBI/CBI) that are community-specific and culturally-appropriate. Native Aspirations provides extensive TTA to the communities to plan for and conduct key project events and activities, including: a Community Readiness Site Visit, a Gathering of Native Americans Event, a Community and Mobilization Planning Event, and the development and finalization of a Community Prevention Plan, Sustainability Plan, and providing mentoring opportunities to ensure the continuation of its prevention strategies beyond the duration of the project. TTA is customized to meet the unique needs of each community. Examples of additional TTA provided to communities includes: identifying and addressing barriers to implementation of prevention activities, forming an operational and active oversight panel to move the prevention efforts forward, designing community outreach strategies, tips for finding grants, and bullying prevention for school- and community-based programs.

How is Native Aspirations evaluated?
Native Aspirations has a two-part evaluation: A process evaluation conducted by KAI to help determine how Native Aspirations is working and if it has been implemented correctly; and an outcome evaluation conducted by Macro International Inc. that examines the impact, benefit, or change within individuals and communities as a result of Native Aspirations.

How does Native Aspirations benefit communities?
Native Aspirations benefits AI/AN communities by facilitating the development of a community-driven, proactive response to youth violence, bullying, and suicide. The focus on knowledge transfer and building community capacity allows communities to gain an enhanced ability to utilize existing resources in a more efficient manner.

Who can I contact for additional information?
For more information about Native Aspirations contact Gloria Guillory, Project Coordinator, via email at gloria@kauffmaninc.com or phone at (509) 747-4994.

PREPARED STATEMENT OF LAURIE FLYNN, EXECUTIVE DIRECTOR, TEENSCREEN NATIONAL CENTER FOR MENTAL HEALTH CHECKUPS, COLUMBIA UNIVERSITY

Thank you for the opportunity to submit testimony on behalf of the TeenScreen National Center for Mental Health Checkups at Columbia University (National Center) for the Senate Indian Affairs Committee's oversight hearing on youth suicide in Indian Country. I commend the committee for exploring this issue and for continuing to shine a light on the tragedy of youth suicide within our American Indian and Alaska Native (AI/AN) communities. Many opportunities exist to help our tribal young people, yet many challenges remain to actually reach those in need. The Na-

tional Center stands ready to help Congress as it considers ways to identify those in need and improve care to help save lives.

Across our nation, youth suicide remains a significant public health challenge. Each year, 30,000 Americans die by suicide, while an estimated 500,000 high school students make attempts. Yet, among our tribal communities, mental illness and suicide is an even greater threat. According to the Centers for Disease Control and Prevention, on our tribal lands suicide is the second leading cause of death for individuals age 10 to 34. Further, when compared with other racial and ethnic groups, AI/AN youth have more serious problems with mental health disorders related to suicide, such as anxiety, substance abuse and depression.

Today's hearing provides Congress with an opportunity to take action to improve mental health care delivered to AI/AN populations. The starting point for this change should be the Indian Health Service (IHS). Since enactment of the Indian Health Care Improvement Act (IHCIA) in 1976, the IHS has not kept pace with the modernizations taking place in the rest of the American health care system. For example, mainstream American health care is moving out of hospitals and into people's homes; focus on prevention has been recognized as both a priority and a treatment; and, coordinating mental health, substance abuse, domestic violence and child abuse services into comprehensive behavioral health programs is now standard practice. There is a critical need for mental health promotion and disease prevention activities in Indian Country. The National Center strongly encourages Congress to incorporate coverage of mental health checkups into the IHS. Making this change will give providers the tools needed to identify adolescents at risk for mental illness or suicide and take steps necessary to intervene and provide care.

The availability of mental health services also is severely limited by the rural, isolated location of many AI/AN communities. Adding to the difficultly of accessing services, IHS clinics and hospitals are located on reservations, yet the majority of AI/NAs no longer live there and only one in five American Indians reports access to IHS services. Furthermore, AI/AN tribes that are recognized by their state, but not by the Bureau of Indian Affairs (BIA), are ineligible for IHS funding. Moreover, there are fewer mental health providers, especially child and adolescent specialists, in rural communities. The National Center encourages Congress to take steps to expand and coordinate care for AI/AN populations not living on or near reservations.

Understanding the nature and the extent to which AI/ANs utilize mental health services is limited by the lack of research. The 1997 Great Smoky Mountain Study examined mental health service use among Cherokee and non-Indian youth living in adjacent western North Carolina communities. Among Cherokee youth with a diagnosable psychiatric disorder, one in seven received professional mental health treatment. This rate is similar to that for the non-Indian sample. However, Cherokee youth were more likely to receive this treatment through the juvenile justice system and inpatient facilities than were non-Indian youth. Similarly, in a small study of Plains Indian students in the North-Central United States, more than one-third of those with psychiatric disorders used services at some time during their lives. Two-thirds of those who received services were seen through school; and just one adolescent was treated in the specialty mental health system. Among those youth with a psychiatric disorder who did not receive services, over half were recognized as having a problem by a parent, teacher or employer.

The National Center was created to advance greater access to mental health checkups for America's youth. Our screening program is evidenced-based and was highlighted in the 2003 President's New Freedom Commission Report. TeenScreen also is included in the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Registry of Evidence-based Programs and Practices (NREPP) as a scientifically verified intervention in the areas of suicide prevention and early identification of mental illness. I am proud to say that the National Center is funded entirely by a private, philanthropic family foundation whose founders had personal experience with suicide and mental illness. We provide our tools, training and technical assistance at no cost, and there are no fees to participate in our screening program. Our goal is to incorporate mental health evaluations as a routine part of medical care for teens.

To accomplish this goal, the National Center is exploring partnerships with primary care providers, mental health organizations and elected officials in the nation's Capitol and state capitols across this country. The National Center currently has collaborations with eight primary care entities in six states. These partnerships are exploring effective models of incorporating teen mental health checkups into wellness and other health care visits. They include:

- Cincinnati Children's Hospital Emergency Department, Ohio
- Federally Qualified Community Health Center, New York

- ValueOptions, New York and Colorado
- GHI, HIP and Emblem Health, New York
- Kaiser Permanente, Colorado
- Aurora Health Care, Wisconsin
- Nevada EPSDT, Clark County Children's Mental Health Consortium and the Nevada Office of Suicide Prevention, Nevada

The National Center also has community-based mental health screening programs operating in over 530 communities, 11 of which are focused on tribal populations. The communities focused on tribal populations include:

- Bena, Minnesota
- Juneau, Alaska
- Las Cruces, New Mexico (three sites)
- Ruidoso, New Mexico
- Belocourt, North Dakota (two sites)
- Fort Yates, North Dakota
- Wakpala, North Dakota
- Anadarko, Oklahoma

As Congress considers steps needed to reform our nation's health care system, we urge you to incorporate much needed changes and improvements to the care delivered to our AI/NA populations, in particular the mental health services available to AI/NA youth. One critically important and cost-effective step Congress can take is to integrate mental health checkups into the annual exams and medical visits America's young people, and in particular AI/NA youth, receive. Doing so will provide the foundation from which to build other improvements and take the first, and most important step, toward reducing the rate of suicide within our tribal communities.

Thank you for the opportunity to testify. I stand ready to help the members of this Committee develop policies that will improve the lives of AI/NA youth.

Prepared Statement of the Oglala Sioux Tribe

"Most of our days are spent going to school, coming home watching T.V., playing video games and just hanging out with other kids". "We don't have places to go to like movies, hockey rinks, or swimming pools, we just hang out, it gets depressing and sometimes feels hopeless" "No wonder some choose to leave home for a while, others choose to leave forever!!"
Quote by: 17 year old female youth on the Pine Ridge Reservation who attempted suicide twice in one year.

The Oglala Sioux Tribe is located on the Pine Ridge Reservation in south western South Dakota. The Pine Ridge Reservation is larger than the state of Connecticut- over 7,000 square miles and has a population of approximately 42,000 tribal members. Of this population, over 45 percent are ages 18 and younger and 18 percent is between the ages of 15 and 24. Within the Pine Ridge Reservation there are nine districts and 52 communities, the Pine Ridge Reservation is highly rural and isolated.

Last year there were 144 suicide attempts on the Pine Ridge Reservation, unfortunately, we had five completions with two of these suicides being in the same community, within 24 hours. At this time there were no suicide prevention services available for the Tribe. The effects of the community were devastating.

The Oglala Sioux Tribe Sweetgrass Project is funded by SAMHSA to provide suicide prevention services beginning October 2008. The grant provides culturally sensitive community based services to the Oglala Sioux Tribal members. Although the Tribe is humbled by the award, we are finding that our need far exceeds the funds obligated in the grant. Examples of this include the need for clinical services such as psychiatric nurses and licensed mental health technicians to work with our cultural elder leadership. The grant provides 7 new positions for a population of 42,000 people, as stated before we are grateful, but the fact is we are in dire need of more funding for direct services.

In November 2009, one month after the funding of the Sweetgrass Project; we lost two young men to suicide; both were 17, and completed their suicide by hanging themselves, different communities but on the same day.

The Sweetgrass project responded to the communities to provide prevention services to surviving family members. Embracing the families, tiospayes (extended families), schools and community with individual and group counseling, traditional Lakota grieving services and community prevention training, it was emotionally exhausting.

Another concern stems from the high dropouts on reservation schools. On the Pine Ridge Reservation the dropout rate is approximately 75%. With that high dropout percentage in schools it parallels the high unemployment, high social/domestic issues, and high suicides on the reservation. With budget cutbacks in schools, counseling positions were the first to be eliminated followed by paraprofessionals. Many students float through the school days without any interaction with adults.

After debriefing and cleansing the staff's spirit, we realized how vast the actual suicide work was for us to endear. You see, the root of suicide work is addressing tremendous areas of need such

as economics, peer pressure, historical trauma, alcohol and drugs, and overall oppression amongst the Lakota people.

On the Pine Ridge Indian Reservation many programs do not have the resources to provide employees quality staff development. Many employees do not have the skills necessary for interventions and support. The Health Administration program and Sweetgrass project is relied upon to provide for all the training needs of all the programs and also respond when called upon. If you notice the name of our project, "The Sweetgrass project, it is from an elder who told us that something as small as a braid of Sweetgrass can help heal a child if they are taught the meaning of it".

As of today, we have not been able to address the other 144 attempts due to the fact that we are providing follow up on the communities that were impacted from the two suicide completions. We have a lot of work to do in 52 communities, it is paramount. We do know from our elders that the answers to our problems our within, and we need to use our culture as the foundation for reclaiming our youths broken spirits.

It is with great concern we ask that the United States Congress does not forget our youth who are struggling daily with whether they wish to live or die.

Respectfully submitted:

Theresa Two Bulls
President
Oglala Sioux Tribe

Lisa Schrader-Dillon, MSW
Health Administrator
Oglala Sioux Tribe

PREPARED STATEMENT OF BRIAN PATTERSON, PRESIDENT, UNITED SOUTH AND EASTERN TRIBES, INC.

On behalf of the 25 tribes of United South and Eastern Tribes, we wish to respond to this issue and ask that our letter be included in the written testimony for this hearing, held on Thursday, February 26, 2009.

Sadly, in Indian Country, we are very familiar with youth suicide. In fact, the suicide rate is an astounding 12%, which is four times the national average. The majority of us personally know a family affected by suicide and have witnessed the tremendous fallout and tragic aftermath. Various addictions, lack of nurturing environments and unavailable services make this a crucial issue that needs to be addressed by Congress.

This crisis affects all levels of society. Teen suicide and its related abuses (substance/domestic/sexual) have no standing in our culture. Dealing with these problems contributes to long-term trauma for our people.

Many of our young people have yet to learn the coping skills necessary to deal with disappointment and temporary setbacks. Maybe they don't have available role models or mentors to help them see a better path to take. Perhaps they have witnessed firsthand a self-destructive lifestyle and that is their only perceived option.

Our culture and heritage are based on long-term vision and planning, with an eye to the future of seven generations. On behalf of USET, we wish to express our gratitude that the Senate Committee of Indian Affairs is addressing this concern. The member tribes of USET remain committed to the best possible futures for our children, to enable them to take their place in today's society.

PREPARED STATEMENT OF RODNEY BORDEAUX, PRESIDENT, ROSEBUD SIOUX TRIBE

Introduction

On behalf of the Rosebud Sioux Tribe in South Dakota, I appreciate the opportunity to submit written testimony regarding the youth suicide crisis occurring on the Rosebud Sioux Tribe Reservation. The 877,831-acre Rosebud Reservation is located in south-central South Dakota consisting of 20 communities within a four county area (Tripp, Todd, Mellette and Gregory counties) and borders Pine Ridge to the northwest corner and Nebraska to the south. Our tribal headquarters is located in Rosebud, SD. Approximately 19,000 members of approximately 26,000 members are domiciled on the Rosebud Reservation.

I, thank you for convening this important hearing on youth suicide in Indian Country. Sadly, the Rosebud Reservation has tragically lost many of our youth and young people to suicide completions. From January 2005 through January 2009 Rosebud has had *37 suicide completions, 617 suicide attempts, and 629 suicidal ideations.* Indian Health Service (I.H.S.) reported 1,272 encounters with different individuals who have completed, attempted or had suicidal ideation. The Rosebud Sioux Tribe has the highest suicide rate in the nation for 10–24 year old males. These are alarming statistics originating from our Reservation. I look forward to working with you and the Senate Indian Affairs Committee in addressing and bringing further awareness to this crisis, which is devastating our communities and Indian Country.

I need to emphasize that Rosebud is working to develop and provide cultural suicide prevention and youth programs. However, we have an overwhelming need for resources to provide these programs. We have developed programs to assist with basic public safety and awareness, substance abuse and mental health, as well as the Boys and Girls Clubs on the Reservation. Additionally, we are supporting our families and communities through our cultural and educational programs.

Wiconi Wakan Health and Healing Center

Rosebud is located in a rural, remote area of Indian Country and relies heavily on funding from the I.H.S. and Bureau of Indian Affairs (BIA) to provide services and resources to our tribal members. Due to I.H.S. and BIA being consistently under-funded, we have turned to our Congressional delegation for assistance in procuring additional resources for substance abuse and mental health treatment facilities and equipment. Rosebud identified a need to create a culturally-based suicide prevention treatment program and facility specific to our tribe.

Rosebud has worked diligently for nine years to obtain funding, to build the current 20-bed treatment facility for mental health, which has been open for three years. It remains necessary to develop additional youth programs to assist in recovery and rehabilitation. Therefore, Rosebud is establishing the Wiconi Wakan (Sacredness of Life) Health and Healing Center, a place to implement the Tribal Youth

Suicide Prevention and Early Intervention Project plan targeting Rosebud children and youth (ages 10–24 years old) on the Rosebud Reservation.

Inherently our youth are sacred and a vital asset to the people of the Sicangu Lakota Oyate. Suicide has created a destructive ripple in the very structure of our Lakota Oyate. The effects of suicide will be felt for generations. The Wiconi Wakan Health and Healing Center will provide a venue for reviving the life of our people.

The Wiconi Wakan Health and Healing Center will significantly contribute to the available scientific knowledge on the mental health status and delivery of services to children and youth on the Rosebud Reservation regarding Tribal Youth Suicide Prevention and Intervention and will provide a valuable template for replication by other Tribal communities throughout the country. Rosebud has developed a Suicide Prevention plan to advocate and coordinate a culturally comprehensive community-based approach to reduce suicidal behaviors and suicides in the Sicangu Lakota communities while facilitating wellness.

The primary purposes of the Wiconi Wakan Health and Healing Center is to strengthen, implement and develop culturally and linguistically appropriate youth suicide prevention and early intervention services for Rosebud tribal members. This level of intervention will include screening programs, gatekeeper training for "front-line" adult caregivers and peer "natural helpers," support and skill building groups for at-risk Rosebud youth, and enhanced accessible crisis services and referrals sources. To be directly informed by parents, youth, and providers within the Rosebud Reservation. To increase awareness of the signs of suicide amongst community, parents, and youth, working collaboratively with other agencies, providers and organizations sharing information and resources by promoting awareness that suicide is preventable.

Rosebud will implement the public health approach to suicide prevention as outlined in the *Institute of Medicine Report,* "Reducing Suicide: A National Imperative." This approach focuses on identifying broader patterns of suicide and suicidal behavior, which will be useful in analyzing data collected and monitoring the effectiveness of services provided. Rosebud will focus on methodology research on suicide and suicide prevention by providing consistent leadership and monitoring of suicide prevention activities.

Collaborative Effort

Recognizing our overwhelming need, the Department of Health and Human Services (HHS) deployed officials from the I.H.S. to spend extended lengths of time on our Reservation and address our youth suicide crisis.

Dr. Kevin McGuinness, Ph.D., MS, JD, ABPP and Dr. Rose Weahkee visited the Rosebud reservation for a second time from December 4th to December 18th 2008. During this visit they worked collaboratively with Victor Douville, Sinte Gleska University Instructor and Lori Walking Eagle, MSW, Executive Administrative Officer for the RST—President's office. Discussions were held regarding systemic influences from the micro to the macro level within the Reservation systems. The Consultation process focused on cultural systems of wellness, cross cultural sharing of knowledge regarding organizational operations and development of systems with the expertise of Rosebud Tribal leadership to integrate "Wolakota" as a principal intervention that will restore balance through the tribe and its communities to its most vulnerable members. The Rosebud Sioux Tribal Council will participate and attend a retreat which will enhance traditional knowledge.

Wiconi Wakan "Sacredness of Life" Suicide Prevention Summit

On July 1–2, 2008, Rosebud hosted the, "Wiconi Wakan Suicide Prevention Summit," in Mission SD at the Sinte Gleska University. While I convened the Summit that morning, our community was burying another youth, which further emphasized the need to discuss and address this crisis affecting our people and communities. Representatives from the South Dakota delegation, state, local, and federal government officials including South Dakota Governor Michael Rounds' Secretary of the Department of Human Service, the Director of the South Dakota Indian Health Care Initiative, HHS Director of Office of Intergovernmental Affairs, and the Substance Abuse and Mental Health Services Administration (SAMHSA) Administrator as well as other officials from the I.H.S. and HHS along with tribal leaders, members, and youth attended and participated, providing experiences and insight in preventing future youth suicide.

As a result of the Summit, the South Dakota Secretary of the Department of Human Services, Jerry Hofer, committed the state to opening more of its SAMHSA grants and resources to Rosebud. The state currently receives a Garrett Lee Smith Memorial Act grant from SAMHSA, which is also known as the "Suicide Awareness Partnership Project," from the State/Tribal Youth Suicide Prevention and Early

Intervention Program. For three years, $400,000 is given annually to the state. At the time of the Summit, Mr. Hofer indicated that the state is in its 2nd year of the grant. The purpose of the Suicide Awareness Partnership Project is to reduce suicide attempts and completions in South Dakota for youths aged 14–24 in 25 high schools and two universities. Mr. Hofer reported that the Todd Country School District and St. Francis Indian School, both located on the Rosebud Reservation whom serve our youth, are pilot schools in the project as is the Sinte Gleska University. Mr. Hofer reported that the state has specifically contracted with the Sinte Gleska University to provide awareness and prevention activities on the Rosebud Reservation.

Rosebud is extremely appreciative of the state providing resources to our schools and youth through the SAMHSA grant. We understand that the grant will be nearing its three-year term and are concerned as to how these programs will continue to operate once the grant is exhausted. We have overwhelming needs in our communities including a need for additional resources to build upon and expand on these imperative programs to ensure our youth are given opportunities for suicide prevention. At Risk Tribes should be allowed to receive block grants like the states from SAMHSA.

None of the Block Grant funding reaches the tribal government for program development and suicide prevention efforts. Currently, the Red Lake Band of Chippewa (Minnesota) are the only federally recognized tribe included with the States that receive Block Grant Funding. Regarding our current suicide crisis the Rosebud Sioux Tribe should be allocated and allowed to receive Block Grant Funding to *eliminate suicides* on our Reservation. Because of our Government to Government relationship which we enjoy with the federal government we should not be restricted from receiving Block Grant Funding. Due to the high rate of suicides in Indian Country Block Grants should be available to those tribes experiencing the loss of their youth to suicides.

Need for Resources to Provide Programs to our Youth

Rosebud has several programs to provide activities and resources to our youth. However, in each of these areas, funding resources are continually problematic for the viability and expansion of the programs. We need a major infusion of funding to serve and support youth in our communities to further their skill sets and provide for training and increase opportunities.

I will now outline several programs which have been proven to be effective for our tribal youth.

- Sicangu Nation Employment and Training Program (SNETP)

The Sicangu Nation Employment and Training Program serves' our youth in the following areas: work experience, on-the-job training, and classroom training. The SNETP receives approximately $208,148 annually to serve the Rosebud Sioux Tribe and approximately 20% of the Crow Creek Sioux Tribe youth.

Additionally, the SNETP has developed and implemented several unique programs which serve our tribal youth:

- Youth Conservation Corp—a collaborative effort with Rosebud, Yankton, Standing Rock, and Cheyenne River Sioux Tribes with the U.S. Forest Service—allows our youth to gain experience in the forestry field while spending time in our sacred Black Hills area;
- Straw Bale Home Initiative—teaches our youth how to build a straw bale home from start to finish in collaboration with the SNETP and Sicangu Wicoti Awayankapi (Housing Authority). This program operates on a "green works" concept; serving the dual purpose of providing for less-expensive homes, and meeting Reservation housing shortage needs.
- Habitat for Humanities—teaches our youth to build a standard home earning a one-year building credit certificate at our local university. Upon obtaining the one-year certificate, our youth are offered full-time employment with the housing authority;
- Penn Foster Online High School Diploma Program—allows our youth (18 to 21 years old) to obtain their high school diploma online.
- Solar Heat Panel Training and Installation—a collaborative effort by the SNETP and Sicangu Wicoti Awayankapi teaches youth a "green works" concept that conserves our natural resources while utilizing solar energy to heat homes.

During the summer of 2008, the SNETP received 689 summer youth applications only 200 youths could be served due to funding constraints. Over two-thirds of interested students reaching out for assistance had to be turned away. Increased funding for the SNETP's youth employment program could have a major, positive impact on

our tribal youth, especially with the high number of suicides that our community has experienced in the past few years. Increased funding will provide for additional resources to extend to the overwhelming number of youth we have been unable to serve. We strive to keep our youth occupied by increasing services in the form of employment, incentives for accomplishments, and supportive services in their endeavors to overcome barriers.

- Community Emergency Response Team (CERT) Training Sessions

Rosebud received funding in 2008 for CERT Training Sessions for our youth, which were extremely effective in training, providing knowledge and skill sets regarding emergency medical response and preparedness. Rosebud held two sessions of CERT training, which trained over 100 youth in our communities. The tribal youth that were trained under this program developed important set of skills which led to aiding tribal members in emergency medical situations and prevention. Rosebud has a major need to continue providing this vital training opportunity for our tribal youth. The CERT Training prepares our youth for emergencies and events for when our Emergency Medical Services arrive on the scene. The training empowers our tribal youth to seek medical positions. Having trained tribal youth in our communities provides increased medical and public safety, especially in light of our expansive rural Reservation. Rosebud greatly supports this program and seeks to receive additional funding to serve more of our tribal youth.

- Boys and Girls Clubs

To be completely effective in helping prevent youth suicide we need Boys and Girls Club centers in all 20 of our communities. Rosebud has 20 communities on the Reservation, but there are only three small Boys and Girls Clubs. Despite this fact, the Rosebud Sioux Tribe Boys and Girls Club plays' an important role in providing activities and a central place for our youth to gather. To fully reach all of our tribal youth on the Reservation, we need funding to provide additional recreational facilities, activities and programs for all of our communities.

Conclusion

Rosebud understands and has intimately experienced the devastation youth suicide has on our families, communities, and Tribe. With 37 suicide completions in less than five years, Rosebud is deeply concerned and focused on preventing suicides on our Reservation. Although we are working to develop and expand our programs by incorporating culturally-based components and curriculums, funding and resources remain a major obstacle. The federal government has a trust responsibility to Tribes, and Rosebud greatly appreciates the collaborative efforts among the state and federal government. However, we still have major needs and funding deficiencies that must be addressed. To increase the number of highly-trained individuals specialized in suicide prevention for each of our communities would be monumental in addressing our crisis.

We need additional resources and flexibility in the use of funding to provide, create, and maintain programs that incorporate culturally-based components that connect and are tailored for our youth. Tribes need access to resources, trained health care professionals, and prevention programs to adequately address this crisis that continues to plague our Reservation.

Thank you, for holding this very important hearing for Indian Country, giving us the opportunity to express our views and concerns regarding tribal youth suicide.

PREPARED STATEMENT OF LEROY M. NOT AFRAID, MEMBER, GREAT CROW NATION

My name is Leroy M. Not Afraid! I am a *teenage suicide survivor!* I am enrolled member to the Great Crow Nation in Montana! I am also the Justice of the Peace for Big Horn County, Montana.

The signs of teenage suicide are not always obvious. Often we may make the mistake that a young person has to be into drugs, gangs, or other negative behavior's concerning the prerequisites of teen suicide. My story will give you a different point of view;

In 1989, I was a teenager that was looking for attention in the realm of education and athletics! I became the ideal student-athlete. What the public did not see or know behind the show I presented was hurt, pain, and fear. I was using the glamour of being an outstanding citizen to hide the anguish I felt as a young person! I did not want the world to see who I really was. I acquired A's and B's, became Student Body President, and became the captain of both the basketball and cross country teams to hide who I really was. A young man with no other alternative's!

I thought being the best in everything would bring me serenity and hope for the future. It did not, as I would look in the mirror on a daily basis, "I was ashamed of who I was and where I came from!" I wanted to die!

Then one evening, I was home alone in my bed room. I loaded my 6mm hunting rifle, put it under my chin and I wanted to pull the trigger! I thought of my childhood being born and raised on the Crow Indian reservation. I asked the question(s), "Why didn't my own parents raise me? Why did my grandparents raise me? Why are my natural parent's alcoholics? Why did my natural mother run from me when I tried to take her home while she lived the on the streets of Skid row? Why does not my father visit me when he says he is?" These very same questions are being asked by today's youth. "I know" I visit with them in the courtroom on a daily basis. I meet with them as I go on the road throughout Indian country as a *motivational speaker on suicide issues.*

I understand the loneliness, depression, oppression, and anguish the young people feel in Indian Country! I am one of them. The signs are deep and real. We must work together in unity to fight this horrible situation. Suicide after all is a permanent solution for a temporary problem.

Today, I look back! By the grace of the Creator I did not pull the trigger. I got the help I needed! I got into counseling and very involved in my native spiritual ways! That's what saved my life.

So many young lives have been cut short! Potential lost forever! The young ones never live their dreams. Leroy Not Afraid has gone on to become the *First Native American elected as Justice of the Peace in Montana's History!* Thank God, "I did not pull the trigger!"

Thanks for listening! I would love to share my story with members of congress! AHO!

PREPARED STATEMENT OF HAYES A. LEWIS, DIRECTOR, CENTER FOR LIFELONG EDUCATION, INSTITUTE OF AMERICAN INDIAN ARTS

Good Morning Mr. Chairman and members of the committee. I appreciate the opportunity to present testimony on a topic of grave importance in Indian Country-that being the extremely high rates of youth suicide among Native American youth.

My name is Hayes Lewis. I am an enrolled member of the Zuni Tribe. Presently I serve as the Director for the Center for Lifelong Education at the Institute of American Indian Arts in Santa Fe, New Mexico.

Today, I want to provide an overview of the Zuni Pueblo efforts to reverse a long term trend of youth suicides. I will also highlight the status of prevention activities in New Mexico then briefly review our activities and commitments as tribal colleges to assist tribal communities strengthen their capacity to address critical challenges, and then offer some recommendations to effectively address youth suicide within tribal communities.

The Institute of American Indian Arts (IAIA) is the only congressionally chartered tribal college in the United States. Our academic and arts programs are accredited by the Higher Learning Commission of the North Central Association and the National Association of Schools of Arts and Design.

We serve students from 80 tribes, 23 states, international students and students from area public, private and Bureau of Indian Education high schools. IAIA offers AA, BA and BFA degrees in Studio Arts, Creative Writing, Museum Studies, New Media Arts as well as Indigenous Liberal Studies.

The Center for Lifelong Education provides custom designed training and technical assistance in nine programmatic areas along with extended academic and outreach training opportunities through distance education, applied research and cultural exchanges. We provide services to Indigenous nations and tribal communities regionally, nationally and internationally.

I want to acknowledge the work of all of my colleagues and especially those community members who are on the ground in our Pueblos, our reservation and urban tribal communities and daily work to strengthen our people through their care, skills and efforts.

After conducting these hearings over the years, you are likely to have a grasp of the magnitude and complexity of the issues and current statistics associated with youth suicide.
Over the years a number of promising practices have emerged. Some of these have been community driven initiatives, there have been a number of policy and funding initiatives within the Indian Health service and other national agencies. There have also been legislative initiatives and support at the state and federal levels.

A Promising Practice: Zuni Life Skills Development Program

I am very pleased and grateful for Dr. LaFromboise presence on the panel today. She has spent many years examining the issues of youth suicide in Indian Country, but more importantly, she is a valuable resource to tribes to assist in their efforts to design appropriate prevention programming to end youth suicide.

During my tenure as Superintendent of the Zuni Public School District, I requested that she and her team of experts from Stanford University come to Zuni to assist our community experts to design a culturally based youth suicide prevention and intervention program and curriculum.

Three years were invested in community based research, designing a culturally based approach to address suicide, awareness building and training, refining life skills teaching/learning approaches and plans, meeting with parents, consultation with the Zuni Board of Education and Zuni tribal council, designing and deploying identification and referral procedures, and mobilizing community inter-agency effort in a focused manner to stop youth suicides.

When we had a viable prevention and intervention plan and program in place-the suicides stopped. A long term historical trend had been broken and the page was turned to a new, life enhancing chapter of experiences for the Zuni community and youth.

The strength and viability of the Zuni Life Skills Development Program is evident in the longevity of the impacts in the Zuni community and a track record of over fifteen years where there were no youth suicides in Zuni.

The weakness has been that local policy makers, community agencies, school administrators and the tribal council members forgot how fragile the peace was-they rationalized that since we had not had a youth suicide in years-the problem was solved. The curriculum was relegated to a shelf in the library and the hard gained experience and the value of lost lives was forgotten. The warning signs within the community have been evident for a number of years and recently, the suicides returned.

What did we learn?

Suicide prevention and intervention requires constant vigilance and appropriate action at many levels. This requires a collective energy, commitment, careful orientation, focused

training, community awareness, school and community collaboration strategies, and the creation of effective, culturally responsive policies and protocols. The Zuni school administration and board decided that the energy expense and effort was no longer a high priority, and this effectively stopped the progress to the second stage of community empowerment.

The fact that this did not occur can be traced back to three important reasons: 1) the lack of acknowledgement and acceptance by key community individuals that suicide represented a serious health and safety threat to the entire Zuni community, 2) ineffective tribal and community leadership and advocacy for the health and safety of tribal members, and 3) a decline in collaboration locally and with national health services agencies and resources to address suicide and related issues in systemic and proactive ways.

On a more positive note, we know that the experience and success of the Zuni Life skills Development Program (ZLSDP) gave rise to the American Indian Life Skills Development Program which is available through Stanford University to any tribe or community that are searching for a template for effective suicide prevention and life enhancing programs.

The curriculum and program effectively stops or reduces the incidence of youth suicide when implemented in coordination with tribal/community leadership, parents, students, local and national health services providers.

There has been a rise in youth suicides nationally, so we must continue the search for meaningful options such as the ZLSDP to address this public health crisis. In our search for solutions we must be guided by our success as well as our failures, and learn from each experience.

Youth suicide is preventable

Youth suicide in Indian country is preventable. However the task of positively and proactively ending youth suicide in tribal communities, will require a number of changes of perspective regarding what can and must be done.

Too often, tribes and supporting community agencies, schools and school districts have not taken the initiative to develop proactive strategies to comprehensively address health and safety issues and challenges in a holistic manner. This is not to say that there is a lack of concern or effort, rather there seems to be a lack of priority along with a piecemeal approach which impacts the overall analysis, design and implementation of community based prevention strategy and programming.

Dr. Richard Carmona, U. S. Surgeon General stated previously that "among tribal populations, suicide is not an individual clinical condition, but also a community clinical condition".

I truly believe this to be the case and while we recognize the debilitating impacts of historical trauma and other environmental causes that represent limitations and promote dependency among our people, we must go well beyond this discussion and critically think about ways to demonstrate leadership as well as our individual and collective responsibility to create safe, life enhancing tribal communities.

Until we move to a discussion about the collective tribal loss represented by a single suicide, we will not fully engage the reality that our communities need to be healed in many ways. In this realization we then may find the courage to discuss openly and respectfully the value that a single life represents to the whole, and that self-inflicted death is not acceptable.

In my experiences working in my community, I have witnessed the numbness that results from parents unable to understand why their child took their own life? What went wrong? In their grief they have lashed out at their neighbors, other relatives and even blamed themselves for the death of their son or daughter. The continual loss of life due to suicide adds an immense burden and stress on everyone, particularly the survivors.
There must be a focused community effort, led and supported by the tribal government to comprehensively address the grief and pain of the community, so healing may begin.

Many of our Native American youth attend off reservation public school districts that have demonstrated little sensitivity to their needs, issues and cultural values. School administrators working in public schools serving Indian populations are so bent upon meeting the high stakes demands of testing and Adequate Yearly Progress (AYP) that they have no time to do more than the minimum expected when it comes to responding to the emotional and cultural needs of Native American students. All of these amounts to a message: I'm sorry, but I don't have time for you-you don't count.

The New Mexico Suicide Prevention Activities

A number of important developments have occurred in New Mexico as related to the prevention of youth suicide. While New Mexico has consistently ranked among the top five states for suicide rates in the United States with a rate of between 1.5 to 2 times the national averages, the state has developed a consistent process that maximizes its scarce resources to support all communities to address the challenges of preventing youth suicides.

The creation of the New Mexico Suicide Prevention Coalition has accomplished much to create awareness, provide resources and assist communities tribal and non-tribal to work toward the prevention of youth suicide.

Over the past two years the Center for Lifelong Education has participated as a coalition member and supported coalition efforts by providing workshops and training to tribal and non-native community members, students and service providers in awareness, prevention and capacity strengthening using culturally based approaches to planning and community mobilization.

By prioritizing resources and proactively developing collaborations with tribal communities, the New Mexico Public Health Department has demonstrated that it has a stake in promoting the development of locally developed approaches to meet this extraordinary public health challenge.

Role of tribal colleges in promoting tribal capacity building

Most tribal colleges are at the forefront of interactions with tribal communities. They serve as a valuable resource to intergenerational populations and are available to contribute to the enhancement of tribal capacity and sustainability in areas such as youth suicide and to enhance community health and safety.

The Institute of American Indian Arts takes its role and responsibility to the nineteen Pueblos, Navajo and Apache Nations in New Mexico very seriously.

By initiating the Center for Lifelong Education, IAIA extended its outreach and technical assistance to tribes and has become known as a dependable resource and advocate serving area and regional tribes in a number of critical areas to include suicide prevention. I am attaching a copy of a news article along with a copy of our last youth suicide prevention conference.

Recommendations

I respectfully offer the following recommendations to strengthen tribal capacity to address the health and safety of community members based on our work, experiences and observations.

Make a commitment to designing a unified community wide strategy to enhance life and prevent youth suicide.

In tribal communities in the southwest, the experience at Zuni Pueblo, Dulce (Jicarilla Apache) and White Mountain Apache in youth suicide prevention demonstrate how the dynamics of community perceptions and disability are changed when tribal/community leadership make a commitment to unified, community based action.

Develop comprehensive community plans that address the complex issues that impact youth at home, in the community and the schools.

In Developing a comprehensive action strategy and plan to address the challenges faced by youth we must consider that the challenges of youth today are much more complex than in our day. Not only do today's youth have to contend with social and economic challenges, they must also contend with the fear of other violent behaviors such as bullying in all of the contemporary contexts: cyber bullying, cell phone bullying, racism, homophobia, gang activity.

Tribal and community leaders must take the lead in supporting the establishment of safe and healthy communities.

There also must be a commitment to continue prevention and safe community practices and protocols in a consistent manner when such protocols are established. Tribal leaders must initiate policy that will bring all partners to the table to discuss options and create opportunities to establish safer and healthy communities.

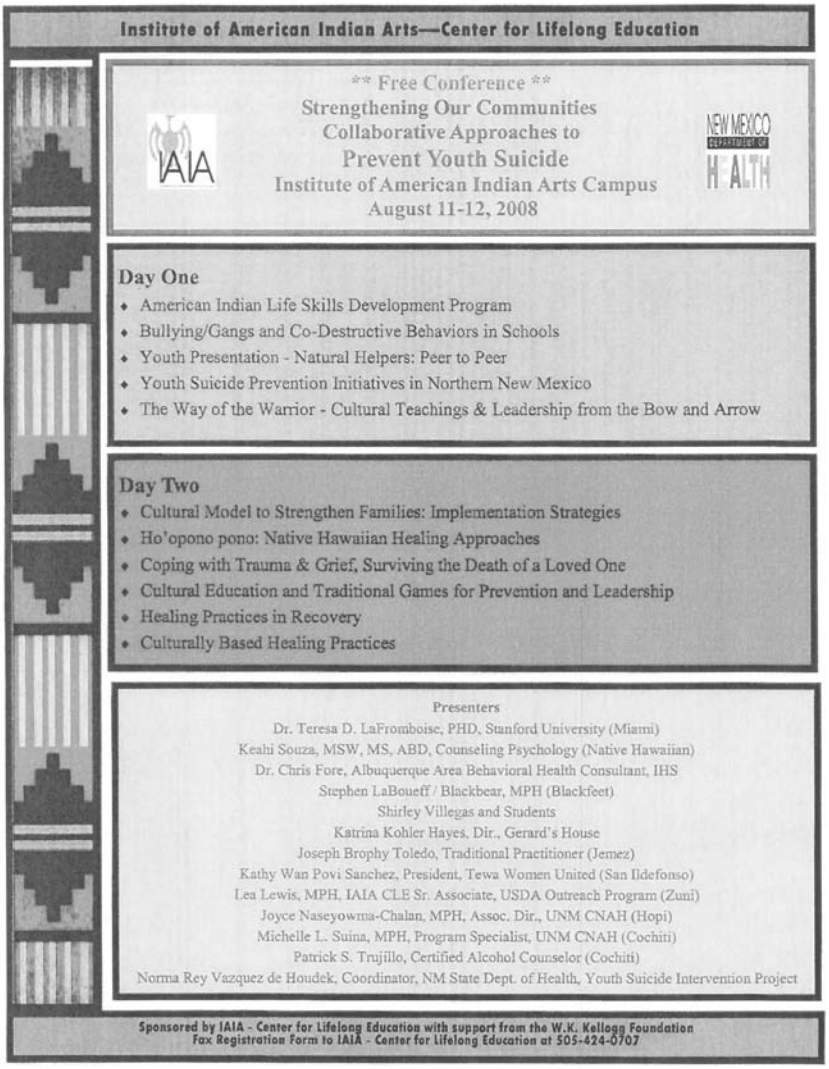
Schools and public districts serving Indian populations must be held accountable and responsive to tribal prevention plans.

School officials and decision-makers must become partners with tribes to promote tribal strategies and prevention needs. This means systematic and meaningful consultations on a regular basis with tribal and community leadership. Not just during a crisis.

Provide funding to support training to enhance tribal capacity to address youth suicide.

This may be accomplished in several ways. Provide funds to agencies such as the NM Suicide Prevention Coalition, to tribal colleges, directly to tribes and /or to agencies such as the Indian Health Service. Many of the service providers and front line workers in our communities are tired of the crisis-response-intervention-dependency syndrome faced by many tribal communities when interacting with outside of community agencies. Under such stressful circumstances, knowledge transfer is not optimal and the feelings of inadequacy and dependency are heightened. Make funds/grants available to tribes with requirements that include stronger collaborations, the design of holistic strategies, training and knowledge transfer.

Thank you for providing this opportunity.


Institute of American Indian Arts—Center for Lifelong Education
** Free Conference **
Strengthening Our Communities
Collaborative Approaches to
Prevent Youth Suicide
Institute of American Indian Arts Campus
August 11-12, 2008
IAIA
NEW MEXICO
H ALTH
Day One
American Indian Life Skills Development Program
Bullying/Gangs and Co-Destructive Behaviors in Schools
Youth Presentation - Natural Helpers: Peer to Peer
Youth Suicide Prevention Initiatives in Northern New Mexico
The Way of the Warrior - Cultural Teachings & Leadership from the Bow and Arrow
Day Two
Cultural Model to Strengthen Families: Implementation Strategies
Ho'opono pono: Native Hawaiian Healing Approaches
Coping with Trauma & Grief, Surviving the Death of a Loved One
Cultural Education and Traditional Games for Prevention and Leadership
Healing Practices in Recovery
Culturally Based Healing Practices
Presenters
Dr. Teresa D. LaFromboise, PHD, Stanford University (Miami)
Keahi Souza, MSW, MS, ABD, Counseling Psychology (Native Hawaiian)
Dr. Chris Fore, Albuquerque Area Behavioral Health Consultant, IHS
Stephen LaBoueff / Blackbear, MPH (Blackfeet)
Shirley Villegas and Students
Katrina Kohler Hayes, Dir., Gerard's House
Joseph Brophy Toledo, Traditional Practitioner (Jemez)
Kathy Wan Povi Sanchez, President, Tewa Women United (San Ildefonso)
Lea Lewis, MPH, IAIA CLE Sr. Associate, USDA Outreach Program (Zuni)
Joyce Naseyowma-Chalan, MPH, Assoc. Dir., UNM CNAH (Hopi)
Michelle L. Suina, MPH, Program Specialist, UNM CNAH (Cochiti)
Patrick S. Trujillo, Certified Alcohol Counselor (Cochiti)
Norma Rey Vazquez de Houdek, Coordinator, NM State Dept. of Health, Youth Suicide Intervention Project
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"I Wish I Would Have..." H. Clay Napie, Jr. Dine

"As a Native American photographer, I feel it is important to show what the issues are on the reservations. Suicide is one of the biggest problems, because more and more Native Americans are giving up on life. Suicide has taken away three of my relatives in the last five years: my uncle Teddy Castiano, Jr., my cousin Shani Castiano, and my cousin Nehemiah Castiano. I realized, through this experience, that you can be hanging out and talking to loved ones one day, and then the next day may be the saddest day of your life because they are gone. I did this project because I wanted people to know that losing a loved one to suicide is hard, but I also wanted to show my respect to each of them and remember them for who they were in life - and how important they were to my family. I don't know why they chose to end their lives, but I did this series of photographs to pay tribute to them and their memory. This project was extremely hard to do these past semesters, but it also started me on a road toward healing. As a Native American photographer I feel that it is important to get this type of work out there and, hopefully, raise awareness and create discussion about suicide"

Strengthening Our Communities: Collaborative Approaches to Prevent Youth Suicide

Jaime Gaskin Eyrich, Program Development Officer
Center for Lifelong Education, IAIA

A sobering and disturbing fact of life in Indian Country is a higher-than-average suicide rate among Native youth: a staggering 2.4 times the national average for youth 15-24 years of age. The State of New Mexico is ranked number five in the United States for total suicides. In order to bring further awareness to issues of suicide in New Mexico Pueblos and surrounding communities, a symposium aimed at preventing youth suicide was held at IAIA on August 11-12, 2008.

Approximately one hundred representatives from Pueblo communities, middle and high schools, universities, and medical institutions were in attendance. Along with experts in the fields of youth suicide, destructive behavior prevention, and gang violence/bullying, a powerful presentation by young peer counselors from Pojoaque Valley High School showed us how students can help stem the rising tide of violence and self-inflicted harm. Native behavioral experts and counselors highlighted the power of prayer and traditional healing practices, and the importance of family and community in the well-being of our youth.

PICTURE
Keahi Kimo Souza
School Social Worker, Native American Community Academy

PICTURE
Teresa LaFramboise
College of Education, Stanford University

The event was sponsored by the Center for Lifelong Education, in collaboration with the NM Department of Health, Office of School & Adolescent Health - Youth Suicide Prevention, and with support from the W. K. Kellogg Foundation.

PREPARED STATEMENT OF JAMES GALLANOS, LCSW PROJECT COORDINATOR, OFFICE OF PREVENTION AND EARLY INTERVENTION SERVICES, DIVISION OF BEHAVIORAL HEALTH

Suicide Rates in Alaska

Data

Alaska has recently adopted the Alaska Violent Death Reporting System (AK VDRS) which is continuing developing itself as a more reliable system of reporting suicide information. We have three years of data from 2003–2005 and will continue this grant for at least two more years. I attached some preliminary reports/ PowerPoint slides above. We also conducted a study, the Alaska Suicide Follow Back Study between 2003–2006 as well as rates for Alaska Native youth over past sixteen years (page 13) up to 79 per 100,000 and higher based on other reports that combine

region with race and age. In general . . . Alaska Natives account for about 16 percent of the state population but account for 39 percent of all suicides. More recent Vital Statistics data show a 5 year running balance (srrates 97–06) and seeing a slight decrease in the Northwest region which is typically highest in the State. See project below in this region.

Projects

Project Life in Kotzebue. GLSMA SAMHSA youth grant (See description attached).

- Lisa Wexler research on acculturation and Inupiat youth suicide.

Suicide Prevention Training

- Gatekeeper Suicide Prevention Training (statewide training and train the trainer model)
- Youth/children residential treatment training protocols
  —Division of Juvenile Justice, trainer, Lindsey Hayes (PowerPoint)*
  —Office of Children's Services/Alaska Children's Services training of residential programs.

Native Aspirations Project

- Kaufman and Associates (see testimony) no other information on outcomes of this independent project.
- American Indian Life Skills training (Theresa LaFramboise)

Comprehensive Prevention and Early Intervention Grants (statewide DHSS program)

- *http://hss.state.ak.us/dbh/prevention/programs/suicideprevention/default.htm*

The Statewide Suicide Prevention Council (2008 annual report attached [last slide Ak Native and US incorrectly placed]).

- *http://www.hss.state.ak.us/suicideprevention/*

GLSMA SAMHSA youth suicide prevention State proposal for FY09

- See attached abstract.

*The information referred to has been retained in Committee files and can be found at *www.ncdjjdp.org/resources/policy__*manual/departmental__policies/18__suicide__prevention/DPSP-0014.ppt

Alaska Suicide Follow-back Study Final Report

Study period September 1, 2003 to August 31, 2006

Prepared for the:
Alaska State-wide Suicide Prevention Council
Alaska Department of Health and Social Services
Alaska Mental Health Trust Authority

Submitted by the:
Alaska Injury Prevention Center
Critical Illness and Trauma Foundation, Inc.
American Association of Suicidology

Acknowledgements

The investigators gratefully acknowledge the support and cooperation of the following agencies and organizations in the completion of this study:

Alaska Statewide Suicide Prevention Council

Office of the Alaska State Medical Examiner

Alaska Department of Health and Social Services

Alaska Mental Health Trust Authority

Alaska Dept. of Public Safety – Alaska State Troopers

Anchorage Police Department

Other local police departments

Funding support:

The Alaska Suicide Follow Back Study was prepared for the Statewide Suicide Prevention Council and was substantially funded through the Alaska Mental Health Trust Authority and the Alaska Department of Health and Social Services.

Executive Summary

Goals

There were two goals for the study: (1) to do an in-depth demographic analysis of the suicides in Alaska for three years from September 1, 2003 through August 31, 2006 and (2) to conduct interviews with key informants for as many suicide cases as possible. This report is divided into two sections, Section 1 addressing the epidemiological data and Section 2 addressing the data derived from the interviews.

Purpose

The purpose of the data gathering, reporting, and analysis was to better understand the etiology and antecedents of suicide among Alaskans, in order to identify potential points of intervention and strategies to reduce the rate of suicide.

Methods

Death certificates attributed to suicides occurring in Alaska between September 1, 2003 and August 31, 2006 were reviewed retrospectively. Information from the Alaska State Medical Examiner, State Troopers, and other law enforcement agencies was collated and reviewed for each suicide death. A cadre of Native and non-Native interviewers was trained in how to use the interview protocol and how to conduct follow-back interviews with survivors of the decedents. All information was entered into a secure database. All efforts to protect confidentiality were in accordance with the Institutional Review Board requirements of the Alaska Native Medical Center, the University of Alaska – Anchorage, and the National Institutes of Health (Certificate of Confidentiality).

Results

There were 426 suicides during the 36 month study period. The average annual suicide rate for the three year study period was 21.4/100,000 (U.S. Census, 2005 estimated population). Males out-numbered females 4 to 1. The age-group of 20 to 29 had both the greatest number of suicides and the highest rate per 100,000 population. Alaska Natives had a significantly higher average rate of suicide than the non-Native population (51.4/100,000 compared to 16.9/100,000). The leading mechanism of death was firearms, accounting for 63% of the suicides. The use of handguns was more prevalent in the non-Native population whereas long guns were used more often by Alaska Natives. The EMS region with the greatest number of Native suicides was Region 4, which includes Bethel and the Yukon-Kuskokwim Delta. Region 2, which includes the Northwest Arctic census area had the highest overall rate of suicide deaths. Follow-back interviews were conducted with 71 informants for 56 of the suicide decedents. Reported alcohol/drug use was the same for Urban as for Rural Native decedents. The same alcohol/drug use pattern was seen for Urban and for Rural non-Native decedents. Toxicology results were received for 31% of all the suicide cases. Alcohol was found in 46% of the toxicology tests and THC (marijuana) was found in 16%.

Conclusion

This study adds volumes of information to our existing knowledge of suicide in Alaska. More in-depth studies are already in progress, which will continue to add to our knowledge base while bringing in additional resources for prevention and treatment. The report also highlights the need for better death data collection, to quantify alcohol and drug involvement and other contributing factors.

Introduction

In 2004, the latest year for which official data are available nationally, suicide was the 11th leading cause of death in the United States for all ages and 3rd among the young. As a comparison, during that same period in Alaska, suicide was the 5th leading cause of death for all ages and 2nd for those under 50. In 2004, there were 155 suicides in Alaska, giving us the highest rate in the U.S. The suicide rate for Alaska was 23.4/100,000 population, more than double the U.S. rate of 11 per 100,000. The estimated years of potential life lost due to suicide in Alaska in 2004 was a staggering 4,686 years. (CDC Wisqars, 2006)

Follow-back studies are used to characterize those who complete suicide by identifying risk and protective factors associated with the death. Suicide risk and protective factors and their interactions form the empirical base for suicide prevention. Risk factors are associated with a greater potential for suicide and suicidal behavior while protective factors are associated with reduced potential for suicide. (Jenkins, 1994; Silverman, 1995) Existing suicide research is strongest in the identification of risk factors, particularly mental and substance abuse disorders, but less developed in non-mental health-related factors, in categorizing protective factors, and only beginning to analyze the unique contributions of individual risk and protective factors as they pertain to specific populations. (U.S. Public Health Service, 1999)

Clear progress has been made in the scientific understanding of suicide, mental and substance abuse disorders, and in developing interventions to treat these disorders. (Stoff, 1997) Much remains to be learned, however, about the common risk factors for self-directed violence and other forms of violence including homicide, intimate partner violence, and child abuse. Expanding the base of scientific evidence will help in the development of more effective interventions for these harmful behaviors.

Understanding risk factors can help those who are unfamiliar with suicide research to understand that suicide is not a random act nor results from a single factor. Protective factors can include a group's attitudinal and behavioral attributes, and the characteristics of the environment. (Blumenthal, 1998) Measures that enhance resilience or protective factors are as essential as risk reduction in preventing suicide.

The Healthy People (HP) Year 2010 Objective 18-1 states "Reduce the suicide rate" to the target of 6.0 suicide deaths per 100,000 population from the current rate of 10.4. (U.S. Department of Health and Human Services, 2000) Accurate information on risk and protective factors for specific populations (e.g., age, sex, ethnicity, etc.) at the national and local level is critical to achieving this objective. Effective intervention strategies must address potentially modifiable social, behavioral, economic, and educational conditions associated with violence. (Gunnell and Frankel, 1994; Rosenman, 1998) However, interventions are often planned and implemented without a systematic understanding of the forces that underlie high risk behaviors in their target populations. One of the recommendations from The Surgeon General's Call to Action to Prevent Suicide is "Enhance research to understand risk and protective factors related to suicide, their interaction, and their effects on suicide and suicidal behaviors". (U.S. Public Health Service, 1999)

Project Outline

Goals

There were two goals for the study: (1) do an in-depth demographic analysis of the suicides in Alaska from September 1, 2003 through August 31, 2006 and (2) to conduct interviews with key informants for as many suicide decedents as possible.

Objectives

1. Identify all decedents whose manner of death was listed as suicide occurring during the study period, as determined by the Alaska State Medical Examiner's Office.

2. Obtain and collate death certificates, medical examiner reports, and law enforcement records for each suicide decedent to form the basis for a demographic description of suicide in Alaska.

3. Further expand the data record for each decedent, where possible, with information from medical, mental health, military and school records.

4. Train a cadre of Alaska Native and non-Native interviewers in the formal follow-back survey instrument.

5. Conduct formal follow-back interviews with key informant survivors of suicide decedents where permissions can be obtained to conduct such interviews.

6. Report all findings in an aggregate fashion.

7. Protect the confidentiality, physical and emotional health of participants in the study in accordance with the Institutional Review Board requirements of the Alaska Native Medical Center, the University of Alaska, and regional Native Health corporations. Obtain a Certificate of Confidentiality from the National Institutes of Health.

Work Plan

Task 1: Identify a detailed methodology for research process; identify problems anticipated in data collection, review and analysis.

Task 2: Develop a detailed follow-back instrument building on previous methods and tools used in similar studies around the world.

Task 3: Obtain formal Institutional Review Board approval of all methods and processes obtained in the study.

Task 4: Develop a computer database for data entry, and analysis of study cases.

Task 5: Implement data collection process. Prepare records on each decedent to be included in the study by gathering such records from all available sources;

removing all identifying information concerning the patient, caregivers, agencies and institutions.

Task 6: Complete data analysis and statistical testing.

Task 7: Provide quarterly, interim, and final reports to the Alaska Department of Health and Social Services, the Alaska Mental Health Trust Authority and the Alaska State-wide Suicide Prevention Council.

Project Methodology

Institutional Review Board Approval

The project methods and procedures were outlined in formal applications to the Institutional Review Board (IRB) of the Alaska Native Medical Center (ANMC) and the University of Alaska Anchorage (UAA). The follow-back study received approval by both of these IRBs. Additional permissions were requested and received from all of the regional Alaska Native Health Corporations, with the exception of the Bristol Bay Area Health Corporation. Approval was also received from the National Institutes of Health for a Certificate of Confidentiality.

Approval for the ANMC IRB took nearly six months and the UAA IRB took almost two months. All of the researchers were required to complete the CITI *Course in the Protection of Human Research Subjects* at www.miami.edu/citireq. One of the stipulations for the ANMC IRB approval, was to that each Native Health Corporation had to provide written approval before any Alaska Native residing in their region could be interviewed. The Bristol Bay Area Health Corporation decided not to participate because they felt the survivors would be too upset by the interview process. The Yukon Kuskokwim Health Corporation and the Tanana Chiefs Conference both required that each community's Tribal Council give their approval before interviews could begin in their communities. Over one year was spent getting approvals to approach next of kin or key informants for the Native decedents. Ultimately, approval had to be given by the person identified to be interviewed.

A natural part of the IRB process required AIPC to develop an Interviewer Consent Form which would explain the interviewee's rights, allow them to terminate the interview at anytime, and assure their confidentiality. The Interviewer Consent Forms were approved by both of the IRB committees.

Case Identification and Survivor Contact

Initial case identification was provided by the Alaska State Medical Examiner's office. Death certificates which were generated for deaths that occurred within the borders of Alaska and whose manner of death was determined to be suicide, were copied and forwarded to the Alaska Injury Prevention Center (AIPC) for inclusion in the study.

Each case was entered into the database at AIPC and given a unique case identifier. Information provided on the death certificate, the medical examiner's report, and the police reports was used to contact survivors for permissions regarding potential interviews.

All of the case identifier information was kept in a locked safe and all of the case files were stored in locking cabinets. Computer files were password protected to maintain a high level of confidentiality.

The study protocol required us to wait for six weeks before contacting the survivors with any requests. Many times the contact information for next-of-kin took more than six weeks to obtain anyway. An initial letter was sent to each next of kin with condolences and an offer to sit down with our trained interviewers to talk about the decedent's entire life. Each request for an interview had a stamped return envelope, so the survivor only had to check a box for "yes" or "no", provide contact information and send it back to AIPC.

Study Population

The final study population included all deaths from suicide occurring from September 1, 2003 through August 31, 2006. Exclusions were made if, after receiving a death certificate, the death was ruled to be other than from suicide or was "undetermined" by the state medical examiner's office.

Major Data Sources and Elements

Death Certificate: Including patient identifier (later stripped), demographics, times and location of death, autopsy involvement, primary/contributory causes of death and manner of death.

Medical Examiner's Report: Including patient identifier (later stripped), mechanism of injury, address of death, next of kin identification, delays encountered and decedent destination, toxicology and blood alcohol levels.

Autopsy Transcript: Including co-morbid factors, quantification of injuries, detailed description of injuries, factors identified which contributed to death.

Law Enforcement Report: Including a description of events leading up to the incident, description of the event, type of weapon or other mechanism of injury and where patient was pronounced dead. This information was documented from Alaska State Trooper and law enforcement agency investigative summaries.

Other Data Sources: Such sources included medical, mental health, court records, employment and educational records when available. Exploration of these additional data sources is ongoing.

Follow-Back Interview Data: The results from the follow-back interviews can be found in Section 2 of this report. The data for the 71 follow-back interviews were entered into a separate database and were analyzed using qualitative and quantitative methods. These data were used to validate the quantitative sources and to make recommendations for further refinement of investigative tools used by law enforcement and medical examiners.

Data Entry and Analysis Process

All data were entered into Microsoft XP Excel for administrative record tracking. A more detailed database, inclusive of all data elements of interest was constructed using SPSS (Statistical Program for Social Science) software, and analyses were performed in SPSS 15. Data were abstracted from each case record using a standardized checklist before computer entry. All data entry into the SPSS database was completed by a single researcher (TLS). Descriptive and non-parametric analyses were conducted. Where appropriate to the statistical test, level of significance was established at .05.

Results

During the three year study period from September 1, 2003 to August 31, 2006, there were 426 suicides identified in Alaska. The 156 suicide deaths in 2004 represent the greatest number of deaths from suicide for more than a decade with the previously high number of 135 occurring in 2000. The suicide rates per 100,000 population for Alaska was 23.4 in 2004, 19.9 in 2005, and 20.3 in 2006.

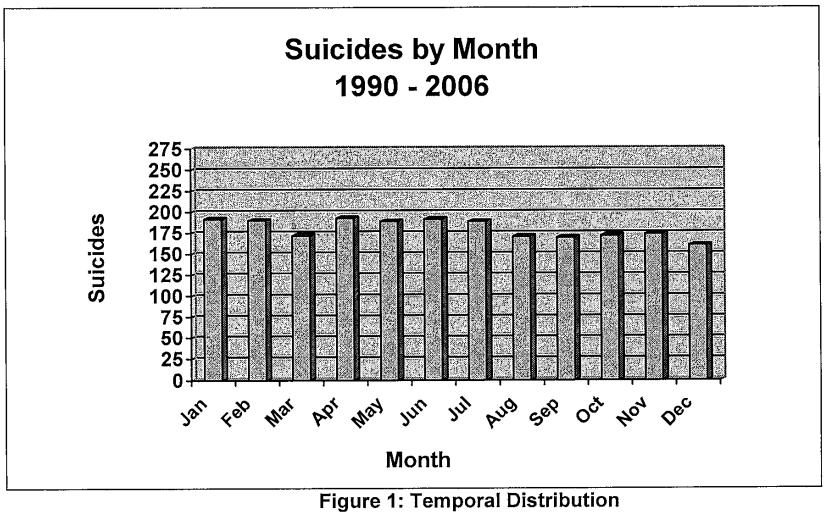

Figure 1: Temporal Distribution

The monthly distribution of suicides was compiled by combining Alaska Bureau of Vital Statistics data for 1990-2003 with data from the Alaska Follow-back study for 2004-2006. The combination of these two data sets provided a 17 year compilation of suicides by month. The resulting distribution ranged from a low of 161 deaths for the month of December to a high of 192 for months of January and June. Figure 1 provides a graphic illustration of this distribution. Tests of significance showed that all of the months fell within the 95% confidence intervals. In other words, there were no months where the number of suicides were consistently higher or lower than the normal distribution.

Age Groups

During the three year reporting period the greatest number of suicides occurred in the younger age groups. Suicides in the 20-29 year old age group (n=118) represented 28% of the total suicides for the study period. Figure 2 represents the age distribution of the suicide cases.

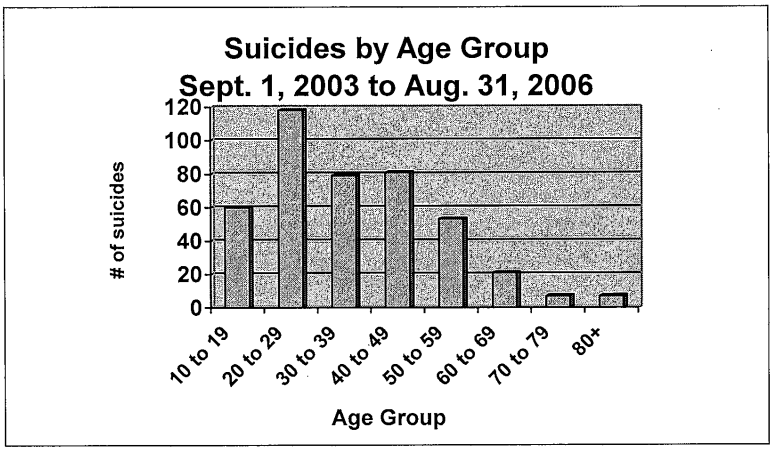

Figure 2: Number of Suicides by Age Group

Since Alaska has a relatively young population (median age 33.2 years), age adjusted rates are necessary for comparisons. A similar distribution is noted when comparing the number of suicides by age group and the rates by age group, with the exception of those over 80.

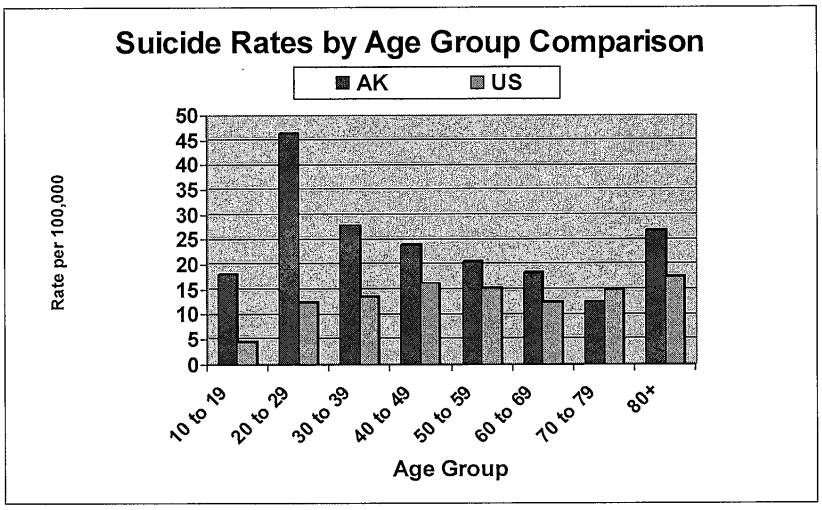

Figure 3: Rates of Suicide by Age Group (2004 est. pop.)

Figure 3 captures the age-adjusted rate distribution for the study period and compares it to the national. The 2004 population estimate was used for both groups.

The age group of 20-29 year olds in Alaska had the highest rate at 46.4/100,000, followed by 30-39 at 27.8/100,000. Nationally, suicide rates are highest in the 80+ age group, followed by the 40-49 group. (CDC Wisqars: 2002-2004) The 20-29 age group is ranked in seventh place nationally.

Ethnicity

The distribution of suicide by ethnicity shows a greater proportion of Alaska Natives taking their own life than the Caucasian or "other" racial categories. Although Alaska Natives comprise 16% of the population, they accounted for 39% of the suicides. Using a combination of statistics from the Alaska Bureau of Vital Statistics and this study, we can show the long term trend for racial disparities in suicides. Figure 4 documents this ethnic disparity.

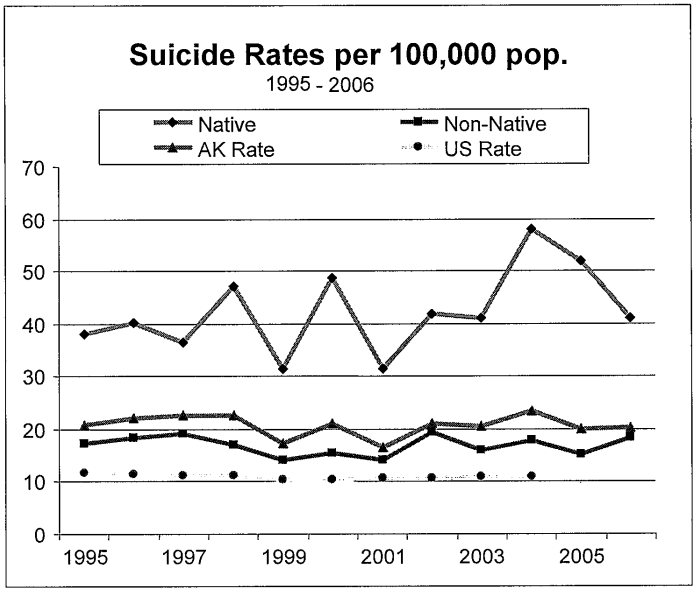

Figure 4: National, Alaska, and Alaska ethnic suicide rates

The Alaska Native rate increased during the three years from 2001 to 2004, and then declined for the past two years. The ethnic disparity is even greater for Alaskan youth 19 and younger, where, over the past 15 years, Alaska Natives accounted for 19% of the youth population and 60% of the suicide deaths in that age group. See Figure 5 for the trend comparisons.

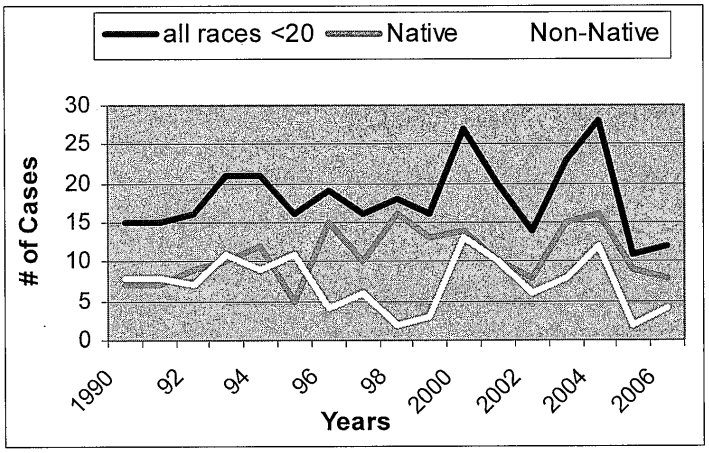

Figure 5. Suicide deaths for Alaskans 19 and younger.

Figure 5 shows the actual number of suicide deaths for youth under the age of 20. The disparity becomes obvious when one sees that the actual number of deaths is higher for Alaska Natives in this age group although the Native population is less. Figure 6 shows a comparison of the death rates per 100,000 population for the 10 – 19 age group. The rates are based on the number of suicides for the actual population in that age group (2005 population estimates).

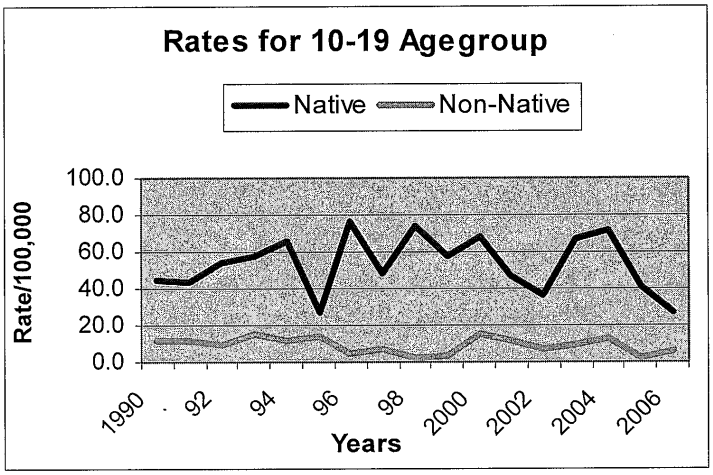

Figure 6. Suicide rates for Alaskans 19 and younger

Mechanism of Suicide

The mechanisms used in the suicides were divided into groups that were consistent with national data. Therefore, hanging, plastic bags, and other forms of suffocation were grouped into "Suffocation". Drug over-doses and carbon monoxide deaths were grouped as "Poisons". Other types of suicide where very small numbers were involved, such as jumping, cutting, drowning, etc. were grouped as "Other".

Choice of mechanism for the suicide act varied significantly between Natives and non-Native Alaskans. The results of a chi square test of association indicated that there is a significant difference between Natives and non-Natives with regards to the mechanism utilized, $\chi^2 = 24.095$ (3, $N = 421$) $p = .000$. Mechanism was reported for 426 cases while ethnicity was reported for 421 of the cases. Of those 421 cases, 262 were non-Native and 159 were Alaska Native.

Table 1 shows the various mechanisms of suicide. The three leading mechanisms of suicide were firearms, suffocation, and poisoning, with firearms accounting for 63% of all suicides.

Mechanism	Native	Non-Native	AK - all	USA (2003)
Firearms	60%(93)	65%(172)	63% (270)	54%
Suffocation	32%(55)	17%(44)	23% (99)	21%
Poisoning	6%(7)	15%(39)	11% (46)	17%
Other	2%(4)	3%(7)	3% (11)	8%
Total cases	**100% (159)**	**100% (262)**	**100% (426)**	**31,484**

Table 1: Mechanism used in Suicide

The proportion of suicides by firearms was fairly consistent between the ethnic groups in Alaska, but the deaths using suffocation (hanging) was nearly twice as high (1.8:1) for the Native as the non-Native decedents. Poisoning (primarily drug overdoses), showed the opposite results, with non-Natives accounting for more than twice (2.5:1) the percentage as the Alaska Natives.

The type of firearm used was grouped by handgun or long-gun (rifles and shotguns). Figure 6 shows the comparisons between Alaska Natives and Non-Natives by type of firearm used. Handguns accounted for 34% of all the suicides and long-guns for 27%.

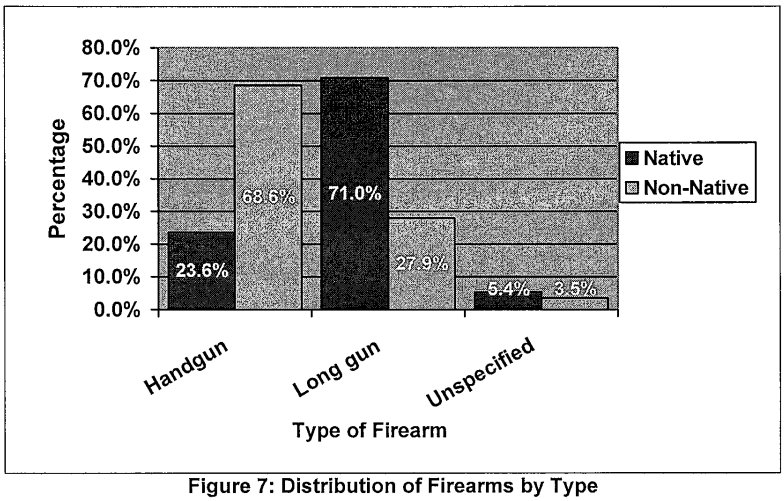

Figure 7: Distribution of Firearms by Type

For the firearm suicides alone, 53% used handguns and 42% used long guns. According to the 1996 Alaska Behavioral Risk Factor Survey, 60% of Alaskan adults reported having a firearm in their home. Forty percent (40%) of these adults reported owning handguns and 54% reported owning long guns. The primary reason for owning a firearm was reported to be hunting or sport (72%).

In 2005, the Alaska Native Tribal Health Consortium's Injury Prevention Program initiated a random sample of 318 homes from 10 villages in southwestern Alaska. Of the 318 homes, 258 completed a survey and 197 of those homes had at least one firearm present (76%). Of the 197 homes with at least one gun, the surveys found a mean of 5.5 firearms per home, with 91% being long guns and 9% handguns.

Regional Differences

During this three year study period there were great variations in suicide rates by region on the state. Rates were calculated by using the number of suicides per 100,000 population for that region. The state EMS regions were used, several of which include more than one borough. Figure 7 shows the suicide rate differences. The regions listed here coincide with the 11 EMS Regions defined by the Alaska Department of Health and Social Services. The regions are made up of the following boroughs and census areas: 1. North Slope, 2. Northwest Arctic, 3. Nome, 4. Wade Hampton and Bethel, 5. Dillingham, Bristol Bay and Lake and Peninsula, 6. Kodiak Island, 7. Aleutians East and West, 8. Anchorage, Kenai and Mat-Su, 9. Valdez-Cordova, 10. Yukon-Koyukuk, Denali, SE Fairbanks, and Fairbanks North Star, 11. Yakutat, Skagway-Hoonah-Angoon, Haines, Juneau Prince of Wales, Outer Ketchikan, Ketchikan Gateway, Wrangell-Petersburg, and Sitka.

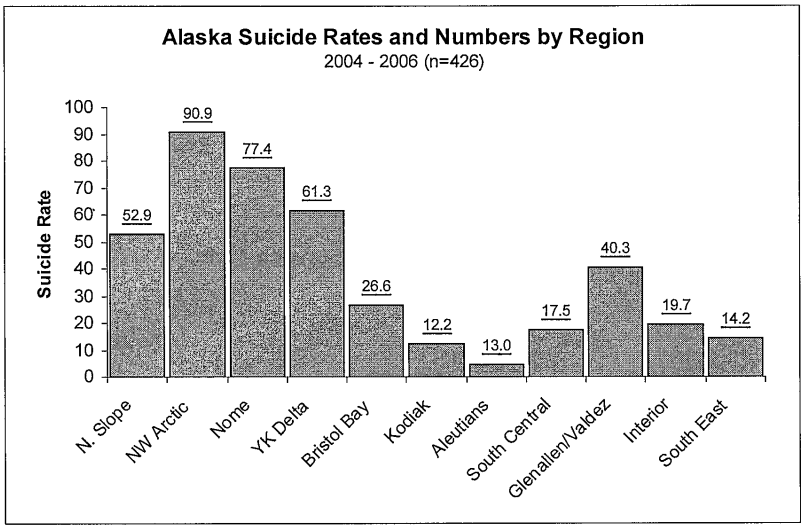

Figure 8: Rates of Suicides by EMS Region

When comparing the current regional suicide rates (from the Follow-back study) with rates from 1990 – 2003, the rank order for the top four regions has not changed: Northwest Arctic, Nome, YK Delta, and the North Slope regions. In more general terms, the northwestern regions of the state had the highest rates and the Aleutians and southeastern regions have the lowest rates. When comparing these rates by the Alaska Native ethnic groups that constitute the majority population in each region, the Inupiats and Eskimos have the highest rates, and the Aleuts have the lowest rates of suicide.

Alcohol/Drug Use

Alcohol and/or drug use at the time of death was combined because the researchers felt that it was a substance abuse issue, rather than the type of substance being abused. A good deal of subjectivity had to be used with this part of the study. For example, alcohol/drug use at the time of death was recorded "yes" (present) or "no" (absent) if it was specifically noted on a reporting form or mentioned by the law enforcement officer investigating the death. Alcohol/drug use was recorded as unknown if it was not mentioned in the investigative reports.

Toxicology tests were requested and samples were taken for 195 deaths, with 139 (33%) of the 426 decedents having toxicology results in their files. Of the 139 toxicology tests performed, 61 had a measurable alcohol level in their blood at the time of death, and 67 decedents tested positive for one or more drugs. We excluded drugs from this category which were non-addictive prescription or over the counter drugs (anti-depressants, Tylenol, etc.) or addictive prescription drugs within therapeutic levels (Oxycodone, Ambien, etc.). THC (marijuana) was found in 31% of the toxicology samples that were positive for drugs.

According to the National Violent Death Reporting System (NVDRS), of the 13 states collecting data on suicides, only one state (Oregon) had a lower toxicology testing frequency than Alaska. (CDC, MMWR 2006) The states with the highest testing frequency were Virginia (97.7%) and Rhode Island (96.5%). In the NVDRS report, Alaska reported toxicology samples tested for 41.1% of the decedents. In our 3-year follow-back study we found that toxicology screens were requested for a total of 46% of the deaths, but results were received for 31% of the decedents. According to this national study, marijuana tested positive in 7.7% of the cases, whereas in our Alaskan study, marijuana was positive in 16% of all the toxicology screens, and 31% of the positive drug screens. THC was the number one drug found, after alcohol, in our study.

When comparing alcohol/drug use for the 426 cases, we found 325 cases where the investigating officers or the Medical Examiner's office reported the use of alcohol and/or drugs by the decedent at the time of death. This "reported" use was positive for 200 cases, negative for 125 cases, and undetermined for 101 cases. Toxicology samples were analyzed and we received reports for 139 cases. The toxicology tests were performed by a commercial laboratory under a contract with the State of Alaska. Table 2 shows the toxicology results that were positive for either alcohol and/or drug use by ethnicity. We found that 72% of the Native decedents were positive, as were 72% of the non-Natives tested.

Native	Non-Native
Toxicology tests completed (n=36)	Toxicology tests completed (n=103)
Positive = 26 (72%)	Positive = 74 (72%)

Table 2. Alcohol/drug use by ethnicity.

Urban-Rural Differences

The U.S. Census Bureau, in their 2000 Census report, made Urban and Rural designations for Alaska based on population density, but this methodology shows Nome, Kotzebue, Barrow and other small rural communities as being Urban. The federal subsistence guideline identifies Alaskan communities having over 7,000 population as being Urban. This definition comes the closest to reality in the culture and lifestyle differences for the Urban and Rural designation. The communities that we considered Urban include: Anchorage, Fairbanks, Juneau, Palmer/Wasilla, Sitka, Kodiak, and Ketchikan. These communities include populations that make up 57% of the statewide total population. Using these Urban designations, we found that 58% of the suicides in our study were from the Urban communities.

Another Urban/Rural comparison was made for alcohol and/or drug use. Alcohol/drug use was indicated or "reported" for 77% of all the cases. Of these 325 cases where alcohol/drug use was reported by the investigating officer, 61% were positive. This highly subjective data must be compared to the quantified lab results shown in Table 3. Table 3 shows the ethnic distribution by Urban and Rural communities and the number of toxicology tests (75%) that were positive for alcohol/drug use for each group.

Urban Native		Urban Non-Native
Toxicology tests completed (n=15)		Toxicology tests completed (n=84)
Positive = 12 (80%)		Positive = 60 (71%)
Rural Native		**Rural Non-Native**
Toxicology tests completed (n=21)		Toxicology tests completed (n=19)
Positive = 14 (67%)		Positive = 14 (74%)

Table 3. Alcohol/drug use by Ethnicity and by Urban/Rural location.

It is interesting to note that the percentage of suicide cases that took place in Urban communities matched the percentage of the statewide population for those same Urban communities. The toxicology results for alcohol/drug use in Urban areas (all races) was 73% and for the Rural areas it was 70%. For non-Natives the toxicology results were essentially the same for Urban as for Rural. The positive toxicology results were considerably higher for the Urban Native group when compared to the Rural Native group. The number of toxicology tests performed was a small sample (31%) of the whole group of suicides.

Missing data

There was a high degree of variability in the information available to the researchers. Many death certificates and a few ME reports could not be supplied to the Alaska Injury Prevention Center. Others had missing data at the time they were transmitted to AIPC. Some of the data fields that were frequently missing included Race, Military, Occupation, Education, and Marital Status. Alcohol use and drug use at the time of death are fields on the Anchorage Police Department's Death Investigation Report and on the Department of Public Safety reports. The Lead Sheet for the ME's office does not have a field for suspected alcohol or drug use. Details about a person's mental state or altered mental state are very important from a public health standpoint and should be routinely gathered by death investigators.

There were 195 toxicology tests requested and 139 received. The 61missing reports could have been due to samples not being collected in the field, the sample not being sent to the lab, or the final test results not being included in the ME report.

The time of injury was documented for 202 of the 426 cases and it showed 51 cases from midnight to 6am, 56 cases from 6-noon, 55 cases from noon-6pm, and 40 cases from 6pm-midnight. Time of injury leading to death was not collected routinely and was based on "last seen" information, making it likely to be unreliable.

Discussion

Three years of data gave the researchers a very good snapshot of the current suicide problem in Alaska. There were however, some limitations involved with this research. It was difficult to obtain all of the information necessary, due to frequently incomplete forms and reports. Numerous death certificates were not available during the study period, which resulted in missing data. Also, the primary concern while investigating suicide

deaths by law enforcement agencies seemed to be the determination of intent and culpability rather than public health concerns.

A research project of this magnitude required Institutional Review Board approval from ANMC, UAA, and a certificate of Confidentiality from NIH. In addition we had to obtain approvals to share information or Memorandums of Agreement with the State Office of the Medical Examiner, the Department of Public Safety (Alaska State Troopers), the Anchorage Police Department, numerous local police departments, hospitals, and other sources of information. With so many different people responsible for each piece of data, it sometimes took months (or not at all) to find the race of a decedent, next of kin, alcohol use, drug use, occupation, education, military experience, etc. Apparently the mortuaries fill out much of the information on the death certificate, so we never saw the updated or amended copy before it was sent to the Alaska Bureau of Vital Statistics.

When comparing rates per 100,000 population with state and national databases, we tried to use the latest common year for which data were gathered and the Census population estimates for that year. Actual numbers were not shown in this report when calculating rates for the EMS regions, due to very small number in some cases.

Alcohol use and drug use at the time of death were combined into a single category. Information for the "reported" use cases was extracted from death investigation reports, while the data for the "tox. tests" was taken from the final lab results.

The Urban and Rural designations were an attempt to look at lifestyle differences for people living in different environments.

Conclusions

Seasonal or monthly suicide numbers fluctuate a great deal from year to year, but when looking at the composite from the last 17 years, we see that there is not a seasonal pattern. Neither is there a statistically significant difference by month. We also looked at suicide numbers during full moon phases to see if there were increased numbers during lunar phases and could find no correlation.

One of the greatest differences between the Alaska and the U.S. national data pertained to age groups with the highest suicide rates. Nationally the highest age group involved senior citizens over the age of 80, followed by the 40-59 year olds. In Alaska, the highest age group was the 20-29 year olds followed by the 30-39 group. The age group of 10-19 year olds was very disparate for ethnicity, with Alaska Natives accounting for 20% of the population in that age group and 61% of the suicides.

When examining the mechanism of suicide within each age group, the 20-29 group had the lowest percentage using a firearm (58%) and the highest using suffocation (35%). The 60+ age groups had an average of 84% using firearms.

The percentage of Natives and non-Natives using firearms was very close but the disparity was greatest for those using suffocation and poisonings. Natives were almost twice as likely to use suffocation (hanging) than non-Natives. Non-Natives were more than twice as likely to use poisons (drug OD) than Natives. When comparing Alaska with national statistics, we are higher in the use of firearms and lower in the use of poisons.

When looking at the type of firearm used by ethnicity, we saw an inverse relationship. Non-Natives primarily used hand guns (69%), while Alaska Natives used long guns (71%) such as rifles and shotguns. This was primarily thought to be due to availability.

The regional suicide rates have remained relatively constant for the last decade with the NW Arctic Borough having the highest rate, followed by the Nome census area, and the Bethel/Wade Hampton census area. The ethnic groups that predominately populate these areas are Inupiat and Eskimo. The Aleut regions have had the lowest rate of suicide during this same time period.

Toxicology lab results were received for 33% of all the suicide cases. Alcohol was found in 46% of the toxicology tests and THC (marijuana derivative) was found in 16% of lab results. Alcohol/drug use resulted in some of the most interesting findings, with Natives and non-Natives having identical usage percentages as shown by the toxicology lab results. The reported use of alcohol/drugs by urban/rural living environments was consistent within the non-Native group, but very different for the Urban and Rural Native groups. Caution must be used when using small numbers, as the variability can increase.

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Alaska Suicide Follow-back Study Final Report

Section 2

Interviewed Cases

Study period September 1, 2003 to August 31, 2006

Introduction and Background

The data contained in this section must be viewed as a small sample of the 426 suicides that took place during the reporting period. We have 71 interviews for 56 cases. Key demographic, social and behavioral factors were analyzed to determine whether the cases in which an interview was conducted varied significantly from non-interviewed cases. It was determined through chi-square analysis that the differences between the two populations were not significant except for the racial/ethnic data.

Follow-back examinations of suicide are a relatively new permutation of the psychological autopsy method of investigation. Follow-back studies are generally distinguished from psychological autopsies in the number of key informant interviews that are conducted on each decedent. Whereas, detailed psychological autopsies often involve 6 or more interviews, follow-back examinations usually involve 1 or 2 such interviews. (Maris, Berman, & Silverman, 2000) It is, therefore, necessary to discuss the psychological method from which the follow-back method has evolved. The psychological autopsy method of examining antecedents related to a suicide is recognized as a valuable research tool. Isometsa (2001) notes, "Psychological autopsy is one of the most valuable tools of research on completed suicide". (p. 379) Cavanagh and colleagues (2003) reaffirm that posit "The psychological autopsy method offers the most direct technique currently available for examining the relationship between particular antecedents and suicide". (p. 395) Cooper (1999) further confirms the importance of the psychological autopsy methods "The psychological autopsy method is thought to be the cornerstone of suicide research, providing more detailed knowledge than other research methods". (p. 468) Gustafsson and Jacobsson, (2000) note that, "Psychological autopsy diagnoses have been proven reliable and valid". (p. 383)

The use of psychological autopsy methods could increase the level and detail of important epidemiological data that have traditionally been noted as missing in law enforcement summaries. Runyan, et al (2003) documents the absence of these key data.

Some information, such as whether the decedent had a history of mental health problems or a left a suicide note was recorded frequently... by the officers we interviewed. In contrast, other information that might help to understand the context of the suicides is not recorded often, including information about a history of drug or alcohol problems, history of child or adult traumas, or information about other precipitating factors. (p. 69)

The psychological autopsy involves conducting structured interviews with family members, relatives, friends and professional personnel who were close to, worked with, or treated the decedent. (Brent, 1989) These interview findings are typically augmented by abstraction of key data elements from medical and psychiatric records. The purpose of the methodology is to "retrieve comprehensive information about a suicide". (Cooper, 1999) (Cavanagh, Carson, Sharpe & Lawrie, 2003) describe the utility of the process.

From this information an assessment is made of the suicide victim's mental and physical health, personality, experience of social adversity and social integration. The aim is to produce a full and accurate a picture of the deceased as possible with a view to understanding why people kill themselves. (p.88)

The psychological autopsy method has been used to describe the role of acculturation and assimilation pressures in displaced natives. (Lee, Chang, & Cheng, 2002 note that previous studies concerning the relationship between acculturation and suicide have

yielded varied results, they suggest that methodological differences likely contribute to these varied findings.

> ... the association of acculturation and mental disorders would be better understood when the scope of acculturation, the types of mental disorders, the targeted population, and other possible confounding factors are carefully defined and systematically investigated. (p. 134)

The psychological autopsy method of investigation provides opportunities to define those "other possible confounding factors". Lee and his colleagues (2002) note that

> The concept of 'anomie' proposed by Durkheim in 1897 to describe the phenomena of social disorganization and weakened social and cultural affiliation has been speculated to be one of the important contributors to the high suicide rates among natives in Australia, Alaska and Manitoba. (p. 134)

The assumption of this study, based on supporting documentation, is that the formal key informant interviews of a follow-back or psychological autopsy process, if not the "gold standard", are at least a lesser precious metal and more accurate by their nature than unstructured police investigations. Gelles (1995) concludes, that, in spite of its imperfections the psychological autopsy is the best tool available.

The psychological autopsy is a postdictive analysis. It is speculative and probabilistic. However, it is the best conclusion giving a logical given a logical understanding of the relationship between the deceased and the events and behaviors that preceded the death... Its specific purpose is to form a logical understanding of death from tangible physical evidence, documented life events, and intangible and often elusive emotional features. (p. 337)

This section of the research focuses on the contributing factors that led to the suicide, an area of critical weakness in law enforcement investigatory summaries. This is often due to the orientation of the law enforcement investigation, even when using psychological autopsy methods. "The psychological autopsy serves as an adjunctive aid... in determining the manner of death". (Gelles, 1995) This statement confirms that the primary orientation is to determine that the suicide is neither a homicide nor an unintentional injury death, rather than collecting data on the antecedents and etiology of the decedent's suicide. These latter factors are the greatest interest to suicidologists who continually strive to find effective prevention opportunities and treatment measures.

The follow-back interviews conducted as part of this research project were based on the best science from previous psychological autopsy and follow-back processes. The tool went through several iterations to make it as pertinent to Alaskan cultures as possible. Specific training was conducted in the use of the tool. The following pages capture the essence of the quantifiable data from the interviews that have been conducted to date. Again, caution must be exercised in the use of these data. As additional interviews are conducted and added to this pool of information, the confidence and reliability in these data will increase.

Methodology

Seventy-one (71) interviews were conducted for 56 cases. Where multiple interviews were involved, the researchers chose the most reliable source for the interview answers.

The project methods and procedures were outlined in formal applications to the Human Subjects Review Committee of the Alaska Native Medical Center (ANMC) and the

University of Alaska Anchorage (UAA). The follow-back study received approval by both of these IRBs. Additional permissions were requested and received from all of the regional Alaska Native Health Corporations, with the exception of the Bristol Bay Area Health Corporation. Approval was also received from the National Institutes of Health for a Certificate of Confidentiality.

Approval for the ANMC IRB took nearly six months and the UAA IRB took almost two months. All of the researchers were required to complete the CITI *Course in the Protection of Human Research Subjects* at www.miami.edu/citireq. One of the stipulations for the ANMC IRB approval, was to that each Native Health Corporation had to provided written approval before any Alaska Native residing in their region could be interviewed. The Bristol Bay Area Health Corporation decided not to participate because they felt the survivors would be too upset by the interview process. The Yukon Kuskokwim Health Corporation and the Tanana Chiefs Conference both required that each community's Tribal Council give their approval before interviews could begin in their communities. Over one year was spent getting approvals to approach next of kin for Native decedents, and then the ultimate approval had to be given by the person we wanted to interview.

A natural part of the IRB process required AIPC to develop an Interviewer Consent Form which would explain the interviewee's rights, allow them to terminate the interview at anytime, and assure their confidentiality. The Interviewer Consent Forms were approved by both of the IRB committees.

Initial case identification was provided by the Alaska State Medical Examiner's office. Death certificates, generated for deaths that occurred within the borders of Alaska and whose manner of death was determined to be suicide, were copied and forwarded to the Alaska Injury Prevention Center (AIPC) for inclusion in the study.

Once received by AIPC, each case was entered into the database and given a unique case identifier. Information provided on the death certificate, the medical examiner's report, and the police reports was used to contact survivors for permissions regarding potential interviews.

All of the case identifier information was kept in a locked safe and all of the case files were stored in locking cabinets. Computer files were password protected to maintain a high level of confidentiality.

Most of the potential interviewers were recommended by the various regional Native Health Corporation's mental health units. The initial training session was held in Anchorage in October 2003. The Alaska Injury Prevention Center paid for one participant from each corporation, but three of the corporations paid for additional staff to attend. A total of 35 interviewers were trained over the course of the project with 13 actually being asked to conduct interviews. All interviewers were trained counselors and were asked, as part of the training process, to conduct mock interviews. The instructors would then provide with feedback for improvement. This process also gave the study team an opportunity to select the best interviewers.

The study protocol required us to wait for six weeks before contacting the survivors with any requests. Many times the contact information for next-of-kin took more than six weeks to obtain anyway. An initial letter was sent to each next of kin with condolences and an offer to sit down with our trained interviewers to talk about the decedent's entire life. Each request for an interview had a stamped return envelope, so the survivor only

had to check a box for "yes" or "no", provide contact information and send it back to AIPC. If a potential interviewee said they would like to be interviewed, an interviewer was assigned to the cases. The interviewer arranged a meeting for the interview.

RESULTS

Demographic Information

The questions concerning demographic information give a basic background of the decedent. According to the follow-back interviews, 36% were married or living together as married, and 39% were never married. Of those who had a recent change in their marital status (widowed, divorced, separated), 86% were devastated by the change.

Questions regarding the decedents' origination and residency produced the following results:

- 96% were born in the United States
- 39% were born in Alaska
- 41% lived in Alaska their whole life
- 4% lived in Alaska seasonally

Interviewers reported the race or ethnicity to be 70% white, 23% Alaska Native and American Indian, and 7% as other. Of the decedents from Native ancestry, 46% were Yupik Eskimo, 23% Inupiaq Eskimo, 8% Aleut, and 8% Tlingit/Haida. Of this Native group, 15% attended Boarding school. Fifteen percent had parents who attended Boarding school, and 15% had grandparents who attended Boarding school.

Other results from the 13 Alaska Native interviews indicated that:

- 15% were reported as always speaking their Native language and 54% sometimes spoke it.
- 77% participated in traditional Native ceremonies
- 16% used traditional Native medicine to treat illness
- 77% had a special Native name, with the Native name being reported as very important for 60% of the decedents

Education

When interviewers questioned respondents about the decedent's level of education, the following responses were received:

- 44% had at least some college or higher education
- 25% had less than a high school education
- 9% were in school at the time of their death
- 29% were bullied as youth

Religion

Questions about the decedents' religious activities reported that 29% were not affiliated with a religion. Of the 71% who had a religion 58% were not active, and only 12% were reported to be very active. During the last month of life 60% did not attend any religious services.

Occupation

When asked about the decedents' work life and jobs, the response was that 75% had a paying job during the last year of their life.

Of the last jobs held:

- 13% were professionals
- 38% were in the service industry

The length of time at the last job was reported as:

- less than 1 year for 38%
- 1 to 5 years for 29%
- 10 or more years for 18%

When rating job satisfaction at the last job, the responses were:

- 43% loved the job
- 38% thought the job was "just ok"
- 16% hated their job
- complaints about their job were as follows: difficult co-workers, poor pay, work too hard, and stressful job

Queries involving the decedents' recent job history produced the following results:

- 52% were employed by a private company or business; 11% worked for family business
- 32% started a new job during the last year of their life
- 36% experienced a major change in employment, with 50% taking a demotion
- 54% stopped working during the last year, with 20% getting fired or laid off and 23% quit. Another 17% stopped working for mental health reasons.

The main source of income for 50% was their current job. Fourteen percent stated the decedent was living with, and relying on relatives or friends at the time of their death.

Military

Sixteen percent of the decedents served in the military, with the vast majority serving in the Army. Of those who served in the military, 44% had combat experience, either in Vietnam (75%) or the Gulf War (25%).

Access to Care

When questioned about health care availability during the last year of life:

- 39% were seeing a counselor or therapist. Of those, 18% were seeing a religious leader and 78% were seeing other therapists; of those seeing a therapist, a psychiatrist was reported 41% of the time
- 50% were still seeing a therapist at the time of death
- 78% of all the respondents did not feel the decedents were getting the mental health care they needed.

Multiple reasons were given for their response about inadequate mental health care. The main reasons were that the decedent didn't believe in counseling or asking for help (29%), had difficulty finding mental health services (18%), or problems paying for treatment (11%).

On questions regarding insurance, the following responses were given:

- 57% had some health insurance, of those 40% had private insurance and 34% had Alaska Native Medical.
- 78% said the insurance plan covered mental health care.
- 36% had difficulty paying for health care

Medications

The interviewers asked about the medications the decedent had been taking:

- 62% were taking prescription medication for mental/behavioral health problems
- 54% were reported to have taken the medications as prescribed
- 54% had insurance that paid for the medications, while 29% reported problems paying for the medications
- 80% reported it was easy to get the medications needed

Cognitive Functioning

The interviewers questioned the respondents about the decedents' ability to think clearly or function during the last year of life:

- 54% had an illness or disability that made it difficult to take care of normal daily activities
- 36% had problems with memory or thinking clearly

Biological Family

This section of interview questions related to the biological family of the decedent:

- 96% were raised by at least one of their biological parents
- 27% were the first born, 22% were the 2nd born, 22% were 3rd born
- 20% had one or more siblings die, and of those siblings, 17% were from suicide
- 30% lost a mother or father but only 6% by suicide
- 35% stated that one or both parents had a drinking problem
- 13% reported that parents had abused prescription or illegal drugs
- 35% had a parent with a diagnosed mental illness, with most (68%) listing depression as the identified problem

- 37% had siblings with a drinking problem
- 30% had siblings with a drug problem
- 28% had siblings with a mental health problem

Activities

The questions in this section were intended to describe the recent activities of the decedent:

- 18% were an invalid or homebound at the time of death; 70% due to overwhelming depression or anxiety
- 43% had activity levels decrease and 46% stayed the same prior to death
- 89% had a hobby or favorite activity, for which 44% had a decrease in participation and 44% stayed the same
- Participation in social activities with family or friends decreased for 44% of the decedents and stayed the same for 50%
- The mean hours the decedents spent watching TV per week was 19, and 10 hours for computer or video games
- 39% moved to a new residence in the last year
- 4% were involved in a homosexual relationship
- 59% had experienced an event that caused a great deal of shame, such as financial (27%), drug or alcohol (21%), sexual relationship (18%), other crime (9%)
- 43% reported that a close family member or friend had died recently
- 55% reported experiencing significant losses, which included death of a loved one, suicide, health, loss of relationship, job, financial
- 18% reported having someone they were romantically involved with having had a pregnancy, miscarriage, abortion, still birth, or gave birth to a child
- 41% had problems with law enforcement, which included theft, assault, DUI, and domestic violence
- 57% were involved in a significant romantic relationship, 67% of which were having significant problems with their relationship.

The First 10 Years of Life

In the first 10 years of the decedents' life:

- 25% experienced the death of a close family member
- 27% experienced a major change in family structure, 73% due to divorce or separation
- 25% experienced a significant illness or injury
- 16% were hospitalized
- 43% had a major change in residence
- 32% experienced a major change in the health of a parent or close family member
- 30% were abused before the age of 10, most often by their father
- 36% were abused as a teen
- 29% witnessed violence or abuse, mostly between parents

Health Issues

Regarding the physical health of the decedents, 59% had significant health problems during their life. During the last six months, 64% of the decedents had seen a doctor for a health problem, and 69% of those said the health problem changed their lifestyle.

Social Support

This section of the interview was to ascertain the people in the decedents' lives who provided them with help or support:

- Only 5% had no close friends or relatives with whom they could feel at ease.
- 89% had one or more people who they could depend on for support or help.
- 57% were thought to be satisfied or very satisfied with the support they received from others; 39% were dissatisfied or very dissatisfied by the support they received.

Alcohol

These questions pertained to the decedents' reported alcohol use, of which 43% drank daily, 20% drank weekly, and 5% drank monthly. During the last month of life, 43% drank a lot or binge drank, 48% did not.

When asked about the decedents' drinking habits and events around drinking, the following answers were given:

- 50% reportedly had a drinking problem in the past
- 35% had attended Alcoholics Anonymous
- 33% were hospitalized or entered in a counseling program because of their drinking problem
- 37% had woke up in the morning not remembering what had happened
- 50% felt guilty about their drinking
- 76% usually had more than 2 drinks at a time
- 26% often drank before noon
- 33% had a drinking problem as a child or adolescent
- 37% got into physical fights when drinking
- Drinking created problems with family members in 59% of the decedents
- 26% lost friends or relationships due to drinking
- 37% sought help for their drinking
- 31% were jailed as a result of their drinking
- 19% had delirium tremens or heard voices/saw things that weren't really there
- 26% had been seen by a doctor, social worker, or clergyman for a drinking related problem
- 19% had been arrested for a DUI

Drugs

The respondents were questioned about prescription medicines and drugs used by the decedents during the last year of life:

- 45% used painkillers, of which 78% had been prescribed by a physician, 63% used as prescribed

- 30% were on sedatives, 75% prescribed, 67% using as prescribed
- 27% were taking tranquilizers, 75% prescribed, 38% using as prescribed
- 48% were on anti-depressants, 92% prescribed, 29% using as prescribed
- 14% were taking mood stabilizers, 88% prescribed, 33% using as prescribed
- 11% were on anti-psychotics, 100% prescribed, 60% using as prescribed

Reported illegal **non-prescription** drugs used during last year:

- 16% took stimulants
- 50% used marijuana
- 10% used cocaine
- 9% took hallucinogens

Psychiatric Symptoms

During the last month of life, 45% of the decedents were reportedly often worried, 32% were often withdrawn, 39% were often impatient or annoyed, and 32% seemed suspicious of others.

Other behaviors, during the last month of life, were reported as follows:

- 61% seemed less able to enjoy things they used to
- 39% exhibited a change in appetite or significant weight gain/loss
- 36% felt fidgety or restless
- 63% were reported to be tired and without energy
- 54% felt worthless or guilty
- 46% had trouble thinking or concentrating
- 37% cried more often or had trouble controlling emotions
- 54% were depressed most of the time for the last two weeks of life

Twenty-seven percent reported a personality change for the better in the last few days of life.

Aggression

Below is the behavior exhibited by the decedents over the course of their lives:

- 70% reported having had tantrums, such as screaming, slamming doors, or throwing things
- 55% got into physical fights with others
- 87% had verbal fights or arguments with others
- 40% had discipline problems in school resulting in suspension
- 45% reported problems with law enforcement
- 43% had instigated problems causing others to call the police

Anxiety

When questioned about fear and/or anxiety attacks, 30% of the respondents said YES and 54% said NO, and 16% did not know. Over 87% did not respond to questions describing the symptoms of anxiety or panic attacks regarding the decedent.

Personality Traits

These questions explored the decedents' personality and habits:

- 56% described as a perfectionists
- 25% described as very strict or rigid
- 69% always wore a seat belt when riding in a motor vehicle
- 37% drove faster than most other drivers, 63% were the same speed or slower
- 60% were active smokers, 58% of those smoked <1 pack/day
- 73% were riders of ATVs, snowmachines, or motorcycles
  - 56% had been in a crash, 28% had been in 7 or more crashes
  - 45% always wore a helmet and 38% never wore a helmet
- 57% described as impulsive

PTSD

This section asked about Post-Traumatic Stress Disorder from events in the decedents' lives. The interviewers discovered that 39% had suffered from a traumatic event such as rape, abuse, war, accident, etc. that may have changed their behavior sometime in their lives. Sketchy information was derived from this line of questioning.

Firearms

Following are the responses given for questions regarding firearms and the decedent:

- 84% owned one or more firearms
  - 98% of these guns were kept in the same home as the decedent
  - 79% were not locked up
  - When known, 42% of the guns were loaded
  - 81% felt the decedent was familiar with the operation and use of firearms

- 66% of the interviewed cases used a firearm in their suicide
  - 23% of these guns obtained the same day as the death
  - 23% the gun was always available

Previous Suicide Attempts

When questioned about previous suicide attempts, 43% of the respondents stated the decedent had made prior attempts, 48% said NO, and 9% didn't know. Excluding the "Don't Know" responses:

- 51% had previous attempts
  - Averaged 1.7 attempts per person
  - When was last attempt:
    - < 1 month = 14%
    - 1-6 months = 19%
    - 7-12 months = 24%
    - 1-5 years = 24%
    - > 5 years 19%
  - Method for most recent of previous attempts:
    - Firearm = 33%
    - Drugs OD = 42%
    - Hanging = 8%

        - Stabbing/cutting = 13%
    - 46% of the previous attempts did not require hospitalization

Thoughts of Suicide

These questions asked about the people who the decedent confided in or sought help from concerning their thoughts of suicide.

- 66% verbally expressed thoughts of hopelessness or a wish to die
    - 84% expressed the thoughts in the last 30 days of life
    - These thoughts were most often expressed to (some multiple answers):
        - 41% to family members - parents, siblings, children
        - 32% to a spouse, former spouse, or intimate partner
        - 22% to a professional - MD, psychologist, psychiatrist
        - 22% to friends
- 23% of the 56 cases expressed suicidal thoughts in other ways like drawing, writing, or pictures
- 50% made specific threats or talked about suicide

Suicide Event

When asked whether the decedent was intoxicated by drugs or alcohol at the time of death, 18% of the respondents said "Don't Know". Of the ones who knew the decedents' condition, 46% said YES they were intoxicated.

Other situations surrounding the event:

- 46% of the decedents chose a place to die where someone would have been likely to find them in less than an hour
- 9% wished to be reunited with a loved one who had died
- 21% tried to get help immediately before or during the event
- 57% planned their suicide
- 36% left a note

Last Year of Life

During the last year of life:

- 21% participated in Public Assistance programs, which included food stamps, energy assistance, social security, etc.
- 18% received aid from other social service agencies, i.e. church, food bank, etc.
- 46% reported the decedent was having serious financial problems

Traumatic Brain Injury

This question was introduced about half way through the research project but of the 28 responses, 9 (32%) said the decedent had suffered a traumatic brain injury at some point in their life.

Civil and Criminal Court Cases

AIPC conducted an investigation of the civil and criminal court cases for the 56 interviewed suicide cases. Not all of the suicide cases had a court history and only those cases over the age of 17 had a legal history that could be documented. There were 35 suicide cases that had a court history. We found an average of 8 cases per person and an average of 9.5 charges per person. Six percent of the court cases were felonies, 52% were misdemeanors, and 42% were violations. The number of court cases seems extraordinarily high, further investigations are needed to compare with a random sample of a control population.

Limitations and Strengths of Data

The data contained in Section B must be viewed as a small sample of the 426 suicides that took place during the reporting period. We have 71 interviews for 56 cases. Originally, we sought to conduct follow-back interviews with at least two key informants of approximately 1/3 of the suicide decedents. This turned out to be impractical for a variety of reasons including our inability to obtain contact information for next-of-kin (NOK), NOK lived in another state, NOK moved after the death, no NOK, NOK chose not to participate. We contacted 217 NOK, of which 92 agreed to be interviewed and 71 actually completed an interview. There were 21 people who agreed to an interview but changed their minds before the interview appointment. Only one person quit during the interview process and that was to go to meet a scheduled flight at the airport.

It was impossible to select a random sample of the suicide deaths for which to conduct interviews, but we have attempted to determine how much the interviewed cases resemble all of the cases. Table 4 shows a variety of demographics and the comparison of interview cases with all cases.

	Interview cases	All cases
Sex: Male	80%	79%
Female	20%	21%
Race: Native	20%	38%
Non-Native	80%	62%
Method: Firearm	66%	63%
Asphyxiation	25%	26%
Drugs	7%	8%
Firearm: Hand gun	34%	34%
Long gun	32%	27%
Location: Urban	79%	57%
Rural	21%	43%
Alcohol/Drug Use: Positive	18%	23%
% positive of those tested	100%	75%

Table4: Comparison of Interviewed cases with All cases

The greatest difference in the Interviewed cases and All cases is seen with the over-representation of non-Natives and Urban cases in the Interviewed database.

Part of the problem in getting more rural Native interviews could be due to the delays experienced getting approvals from the various governing layers that protect the individual next-of-kin living in rural Alaska. We were required to get Institutional Review Board approval from the Alaska Native Medical Center, each regional Native Health Corporation, many times the sub-regional or community government, and then of course the decedent's next of kin. It was not clear why rural Alaska Natives were less willing to participate in the interview process, but when some were asked why, we received responses like, "it is too soon to talk about it", or "I don't want to talk about it – it's too personal". Culturally, many Alaska Natives don't want to talk about their grief and feel that they should be strong enough to deal with it on their own.

AIPC trained thirty-five interviewers throughout the state, so that each region could have local interviewers. This methodology provided local, culturally aware interviewers but it also introduced variability in the interview process. Some interviewers probed more to elicit answers rather than just excepting "I don't know".

Another method we used to determine how representative the Interviewed cases were of the whole, involved using key demographic, social, and behavioral factors found within the "All Cases" database. They were analyzed to determine whether the cases in which an interview was conducted varied significantly from non-interviewed cases. It was determined through chi-square analysis that the differences between the two populations were not significant except for the racial/ethnic data. While this does not mean that the interview cases are a perfect representation of all the suicide cases, it does mean that most of the information gleaned from the interviews is highly likely to be similar for the whole group. The results of the chi square test of association indicated that there is no significant difference between those who were interviewed and those who were not, in terms of gender, $\chi^2 = .040$ (1, $N = 426$) $p = .50$. Examination of the cells, showed that women made up 20.8% of the non-interviewed cases, and 19.6% of the interviewed cases. For the variable of marital status, again, there was no significant difference between marital status and whether a case was interviewed, $\chi^2 = 4.71$ (5 , $N = 378$) $p = .45$. Another important aspect of the study was whether it was reported that alcohol was used close to the time of the suicide. Again, a chi squared analysis was performed and the results determined that there is no significant difference in the reporting of alcohol use between interviewed and non-interviewed cases. $\chi^2 = 1.12$ (1, $N = 327$) $p = .19$. In non-interviewed cases, 61% (n = 200) alcohol use was reported in the record, compared to 68.1% (n = 32) in interviewed cases. Alternatively, 40% (n = 28) of non-interviewed cases did not have a report of alcohol use, and 31.9% (n = 47) of non-interviewed cases did not have a report of alcohol use around the time of the suicide. One aspect in which chi-squared analysis showed that there is a significant difference between the interviewed cases and non-interviewed cases is in the proportion of native and non-natives represented. $\chi^2 = 9.03$ (1, $N = 421$) $p = .002$. In the interviewed group 80.4% (n = 45) were non-native, and 19.6% (n = 11) were native. In the group in which an interview was not conducted, 59.5 % (n = 217) were non-native and 40.5 % (n = 148) were native.

We feel confident that this research project, even with its limitations, is the most comprehensive and important suicide research in Alaska.

Conclusions

Some of the more salient conclusions are:

- For the Native decedents, 77% participated in traditional Native ceremonies and 77% had a traditional Native name.
- The education questions showed that when the 7 "Don't knows" were excluded, 71% of the decedents had a high school education or greater, while the overall Alaska graduation rate was 67%. (Hall, D. Getting Honest About Grad Rates, 2005).
- 71% of the decedents reportedly had a religion but only 12% were active.
- 54% stopped working during the last year, with 20% of those getting fired and 23% quitting.
- 78% did not feel the decedent was getting the mental health care they needed.
- 43% of the decedents didn't have health insurance.
- 62% of the decedents were taking prescription medications for mental health problems at the time of death.
- 54% had an illness or disability that made it difficult to take care of normal daily activities.
- 35% had a parent with a diagnosed mental illness with the majority of them (68%) citing depression as the illness.
- 18% were homebound at the time of death; most of those (70%) were due to depression.
- 59% experienced an event that caused a great deal of shame – many of them (27%) were financial problems, 21% for alcohol or drug problems, and 18% involved a sexual-related problem.
- 57% were involved in a romantic relationship and 67% of those were having significant problems.
- 36% of the decedents were abused as children.
- During the last year of life, 64% had seen a doctor for a health problem, of those, 69% said the health problem changed their life.
- Social support was reportedly available for 89% of the decedents but 39% said the decedent was not satisfied with the support from friends/family.
- 50% of the decedents reportedly had a drinking problem in the past.
- 43% drank alcohol daily and 43% were binge drinkers during the last month. The national Behavioral Risk Factor Surveillance Survey for 2005 shows the national rate for binge drinking was 14.4%, the Alaska rate was 17.5%, and for our decedents it was 43%.
- 48% were taking anti-depressants; of those 29% were taking them as prescribed.
- 54% of decedents used marijuana during the last year of life.
- During the last month, 61% seemed less able to enjoy things they used to, 54% were depressed most of the time.
- Aggressive behavior was exhibited by many of decedents, with 87% having verbal fights or arguments and 55% having physical fights.
- 60% of the decedents were active smokers while the state rate is 25%.
- 84% had firearms available in their homes but only 66% used a firearm in their death.
- 23% obtained the firearm the same day as the suicide.
- 51% had previous made attempts, with 57% of those in the last year.

- 66% expressed thoughts of hopelessness or a wish to die. Most often these thoughts were conveyed to family members (41%) or spouse/partner (32%).
- 46% said the decedents were intoxicated by drugs/alcohol at the time of their death.
- 57% planned their suicide and 36% left a note.
- 46% reported the decedents were having serious financial problems.

A couple of the questions from the Follow-back interviews were also addressed in the 2005 Behavioral Risk Factor Surveys for Alaska. The 2005 BRFSS survey asked about binge drinking and found that 17.5 % of the Alaskan respondents reported binge drinking, 14.4% of the all U.S. respondents, and 43% for the interview decedents. The 2005 BRFSS surveys also asked about smoking and found that 20.6% of the all U.S. respondents were active smokers, 24.9% of the Alaskans, and 60% of the interview cases.

Recommendations

The following recommendations are made after analyzing and reviewing the Alaska suicide data collected over the past three years. There is no intention to criticize any individuals or organizations, but rather to highlight needs or areas for improvement:

Substance Use/Abuse:

- Toxicology screens should be completed on all suicides and equivocal deaths.
  - There is a variety of reasons why this would be difficult to accomplish, but the magnitude of alcohol and drug involvement in suicide deaths should make this a public health priority. Roughly half 46% (195/426) had toxicology screens requested and only 2/3 of those were completed.

- Public health education programs regarding binge drinking, especially its link to suicide should be instituted and supported.
  - Binge drinking appeared to be a contributing factor for the interviewed cases. Among the suicide cases that had a follow-back interview, a binge drinking rate of 43% was reported, which is 2.5 times higher than the Alaska rate (18%), and 3 times higher than the national estimated rate (14%) according to the 2005 BRFSS. 43% of the interview cases said the decedents drank alcohol daily.

- The role of marijuana as a contributing factor in suicides should be investigated further.
  - THC was found in 31% of all the Alaskan toxicology tests that were positive for drug use (non-ETOH) and in 16% of all the toxicology tests received. The National Violent Death Reporting System data indicates 7.7% of the national suicide cases involved marijuana. The interviews indicated the 54% of the decedents smoked marijuana within the past year.

- Smoking should be viewed as an important risk factor or marker for increased suicide risk.
  - The 2005 BRFSS found that nationally 21% of the adult population were active smokers. In Alaska, 25% of the population smoked; but 60% of the suicide cases for which we had interviews, smoked.

Case-Finding:

- Primary care physicians should be trained to screen for suicide ideation, especially in cases that present with alcohol or drug related medical problems and for any life-altering ailments.
  - According to the interviewees, 64% of the decedents were reported to have seen a physician in the last 6 months for a health problem.

- Patients with serious physical illness and/or disability should be monitored for suicide risk; many of these patients would need to be screened through home visits.
  - More than half (54%) of the decedents from the interview cases had a disability or illness that made it difficult for them to take care of normal daily activities. Eighteen percent (10) were homebound at the time of death and 70% (7) of those were due to depression.

- Physicians should routinely screen for depression and should consider treatment with an anti-depressant only in consultation with a mental health professional.
  - The vast majority of anti-depressants are prescribed by physicians who have little or no training in mental health issues. Current literature suggests the most effective treatment for depression is a combination of psychotherapy (particularly, cognitive behavioral therapy) and anti-depressants.

- Special screening and help should be provided for children of parents who are diagnosed with a mental illness.
  - 35% of the decedents were reported to have a parent with a diagnosed mental illness; depression was cited in 68% of these cases.

- Special mental health referrals and treatment should be provided for suicide attempters.
  - 51% (24/51) of the decedents were reported to have had previous attempts. Of the previous attempters, 57% had an attempt in the previous year and an average of nearly two attempts per person. Nearly half (46%) of the previous attempts did not require hospitalization, so outpatient services would also need to be involved.

- One aspect of the screening protocol should look at aggression.
  - 70% of the 56 decedents were reported to have problems with throwing tantrums, 55% had physical fights, and 87% had verbal fights with others.

Mental Health: Removing Barriers to Care

- Alaska should develop an incentive program to encourage more mental health professionals to work here.
  - The interviewees said that 78% of the decedents were not getting the mental health care they needed. Interviewees also spoke of long waiting periods for treatment and/or prohibitive costs. However, 29% reported that the decedents did not believe in counseling or didn't want help.

- Programs encouraging and teaching the importance of medication compliance should be instituted.

- Almost two-thirds (62%) of decedents were reported to have had current prescriptions for mental health medications at the time of their death. Twenty seven of the 56 interview cases (48%) were taking anti-depressants, but only 29% of these patients were taking the medications as prescribed.

- Focus groups should be used to determine what compliance issues are preventing people from using their prescribed mental health medications properly, especially anti-depressants.

- Follow-up contact is needed for the survivors, especially witnesses, of the suicide death.
  - One of the most surprising findings during the follow-back interviews was how therapeutic they were for the survivors. Every survivor who expressed an opinion, said how much the interviews helped them come to grip with the death by being able to talk about it in a non-judgmental situation. One lady said it prevented her own suicide by being able to talk with someone.

Public Health Campaigns

- Public education is needed to remove the stigma associated with depression and other mental health issues.
  - Of the interviewees, 78% felt the decedents was not getting the mental health care they needed. The reason given most often was that they didn't believe in counseling or asking for health, followed by difficulty finding care. The Alaska Mental Health Trust is already making great strides in trying to remove the stigma.

- The 20-29 year old age group should be targeted for a suicide prevention focus and for more in depth investigations.
  - The 20-29 year old age group had the highest suicide rate in Alaska, 3.5 times higher than the national average. They had the highest rate of suffocation and the lowest rate of firearm use. Of the interview cases, 64% stopped working the last year of their life and 64% were prescribed medications for mental health problems, but only 21% took as prescribed.

- Recent unemployment emerged as a significant factor of increased risk, thus those recently unemployed should be targeted for supportive programs and increased surveillance and screening.
  - More than half of the decedents (54%) stopped working in the past year. In Australia for 1967-1992, Eckersley (1992) found that the amount and duration of unemployment predicted suicide rates for those aged 15-24.

- The association between traumatic brain injury and suicide is an important area for further research into the association with suicide.
  - 9 of 25 interviewees (36%) said yes, the decedent had a TBI that altered their life.

- Public education is needed about the high risk of suicide in homes that have a combination of mental illness, alcohol, and accessible firearms.

- 84% (47/56) had access to a firearm but 66% (37/56) actually used the firearm. Only 13 of the firearms were reported locked up and 9 of those decedents used a gun anyway. 79% (37/47) of the people who had access to a firearm used a firearm to take their own life.

- The public needs to be informed about the warning signs and the ways to seek help.
  - 66% of the decedents were said to have verbally expressed their thoughts of hopelessness and their wish to die. 41% of the time these thoughts were expressed to family (parents, siblings, children) and 32% of the time they were expressed to a spouse or intimate partner.

- Financial counseling services to provide free or low cost financial counseling services should be available to everyone. Another service might be to provide financial counseling or curriculum in the high schools.
  - 46% of the decedents reported having serious financial problems, and 36% had difficulty paying for their health care. 41% were getting their income from a source other than their own work.

Death Data Collection

- A standard death investigation protocol and report forms should be developed with input from law enforcement professionals. Some of the investigators are doing an outstanding job but others are simply trying to determine if a crime has been committed or not. Once it becomes obvious that the person died by suicide the investigation is closed. The investigation should be a "death scene investigation" rather than as a "crime scene investigation". A good death scene investigation would gather data about alcohol and drug use, recent traumatic events in the person's life, a brief mental and physical health history, recent or impending legal actions, financial problems, etc.

Further Research Recommendations

- Focus groups to see why people aren't using their mental health medications as prescribed.

- More comparisons of the suicide group findings with other statewide databases to compare and contrast differences.

- Ask similar follow-back questions of living groups of people, such as suicide attempters and/or people who have never attempted.

- The importance of "shame" as a warning sign.

- Why do our 20-29 year olds have a suicide rate that is so much higher than the national rate?

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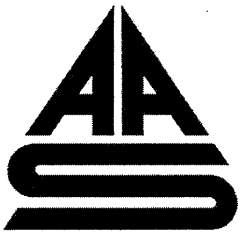
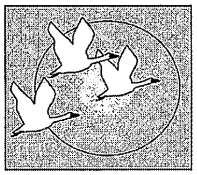
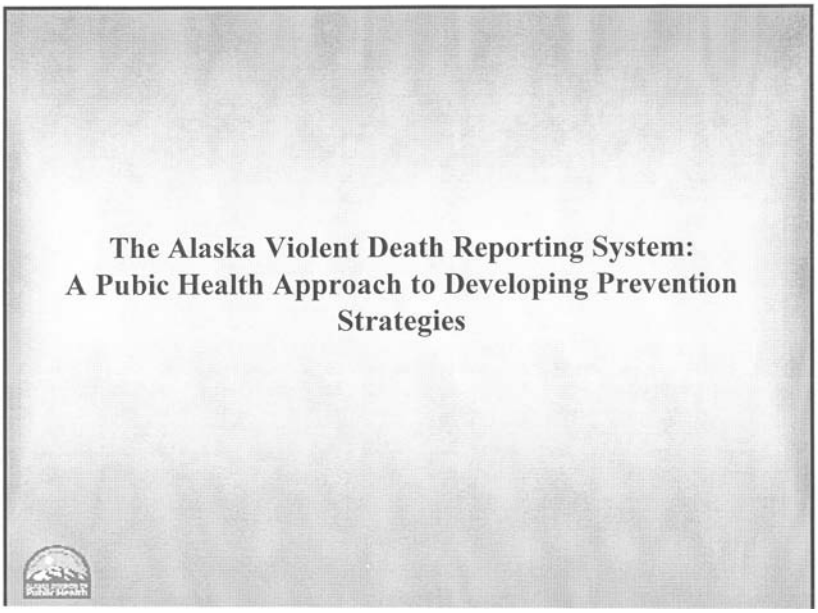




Statewide
Suicide
Prevention
Council

The TRUST
The Alaska Mental Health Trust Authority

The Alaska Suicide Follow Back Study was prepared for the Statewide Suicide Prevention Council and was substantially funded through the Alaska Mental Health Trust Authority and the Alaska Department of Health and Social Services.



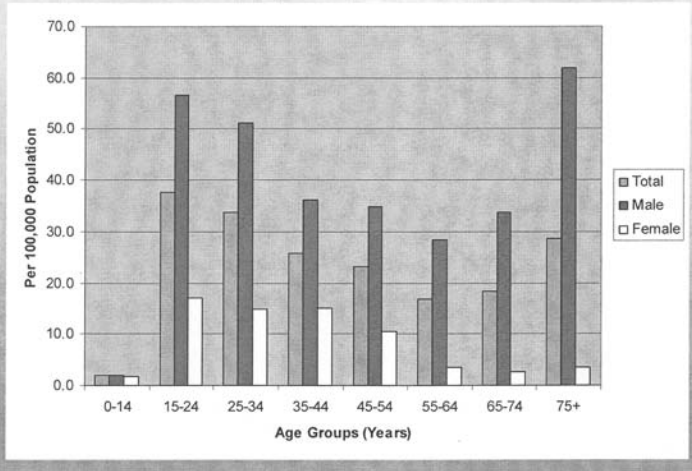
Victim Count, Percent, and Rate of Suicide by Demographics, Alaska, 2003-2005

	Victim Count	Percent of Victim Count	Rate per 100,000
Gender			
Male	328	78.3	32.4
Female	91	21.7	9.5
Race/Ethnicity			
White	241	57.5	17.2
Black	5	1.2	7.0
American Indian/Alaska Native	147	35.1	47.2
Asian/Pacific Islander	11	2.6	12.0
Other	0	0.0	0.0
Two or more races	8	1.9	8.6
Hispanic/Latino	10	2.4	12.4
Unknown	7	1.7	

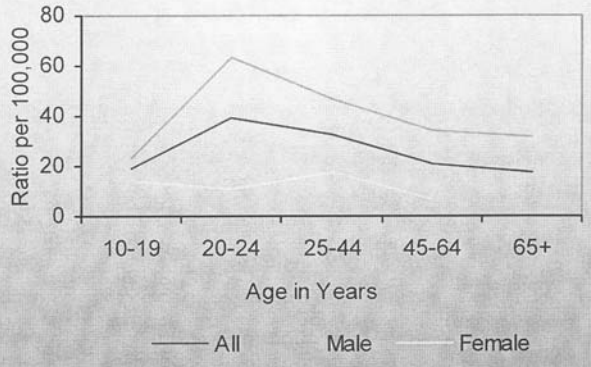
Victim Count, Percent, and Rate of Suicide by Demographics, Alaska, 2003-2005

Age Groups, years of age			
0 – 14	9	2.1	1.9
15 – 24	109	26.0	37.6
25 – 34	89	21.2	33.6
35 – 44	81	19.3	25.9
45 – 54	73	17.4	23.1
55 – 64	30	7.2	16.8
65 – 74	14	3.3	18.4
75 +	14	3.3	28.6
Years of Education			
0 – 8 years	23	5.5	
9 - 12 years	249	59.4	
13 years or more	110	26.3	
Unknown	37	8.8	

Rate of Suicide by Age Group and Gender, Alaska, 2003-2005



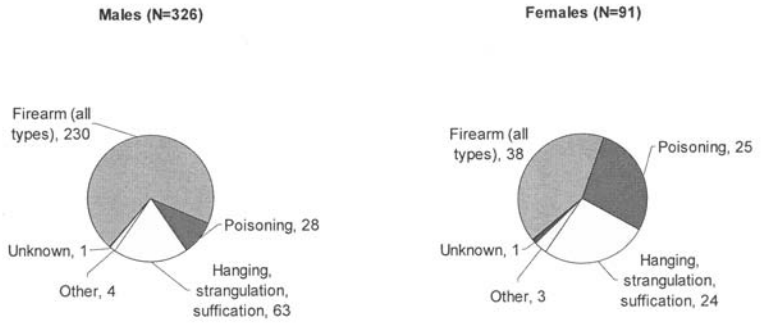
Rate of Suicide, by Age Group and Gender, Alaska, 2004-2005



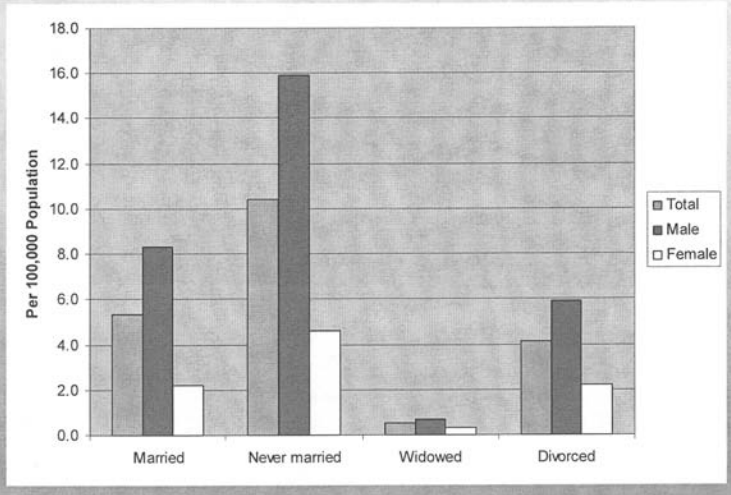
Victim Count, Percent, and Rate of Suicide by Demographics, Alaska, 2003-2005

	Male			Female		
	Victim Count	Percent	Rate per 100,000	Victim Count	Percent	Rate per 100,000
White	198	60.4	27.2	43	28.3	6.4
Black	3	0.9	*	2	1.3	*
American Indian/ Alaska Native	107	32.6	68.1	40	26.3	25.9
Asian/Pacific Islander	8	2.4	18.4	3	2.0	6.2
Other	0	0.0	0.0	0	0.0	0.0
Two or more races	5	1.5	10.7	3	2.0	6.4
Unknown	7	2.1		0	0.0	
Total	**328**	**78.3**	**32.4**	**91**	**21.7**	**9.5**
Hispanic/Latino	7	0.9	7.3	0	0.0	0.0

Method of Suicide, by Gender, Alaska, 2003-2005



Rate of Suicide, by Marital Status and Gender, Alaska, 2003-2005



Victim Count, Percent, and Rate of Suicide, by Region, Alaska, 2003-2005

Region	Victim Count	Percent	Rate per 100,000
Anchorage/Mat-Su	190	45.3	18.3
Gulf Coast	40	9.5	17.9
Interior	57	13.6	18.9
Northern	43	10.3	60.6
Southeast	26	6.2	12.7
Southwest	63	15.0	58.5
Total	419	100.0	21.3

Figure 2.4: Suicide Count by Region, Alaska 2003-2005

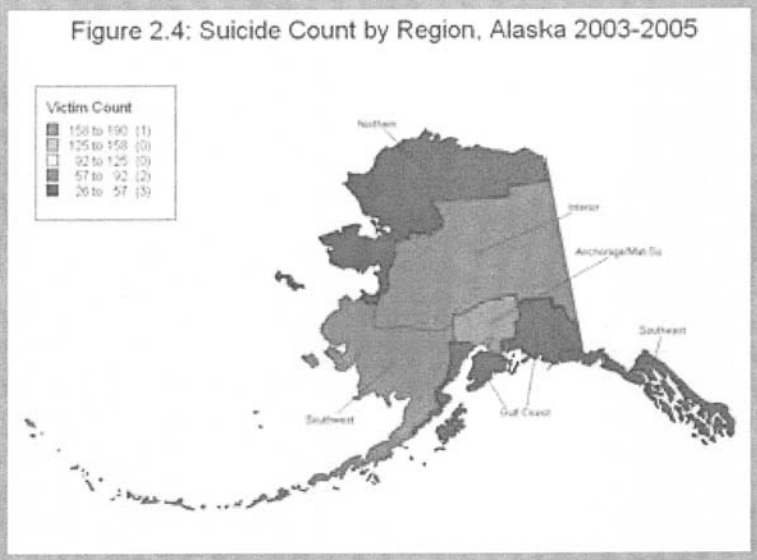
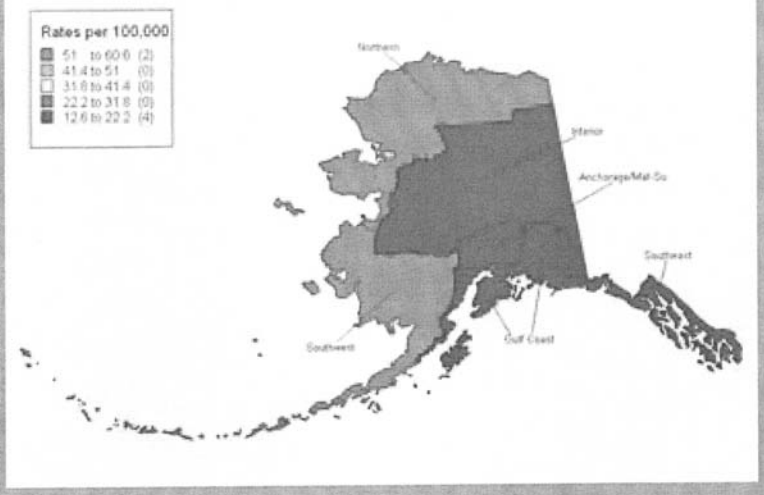
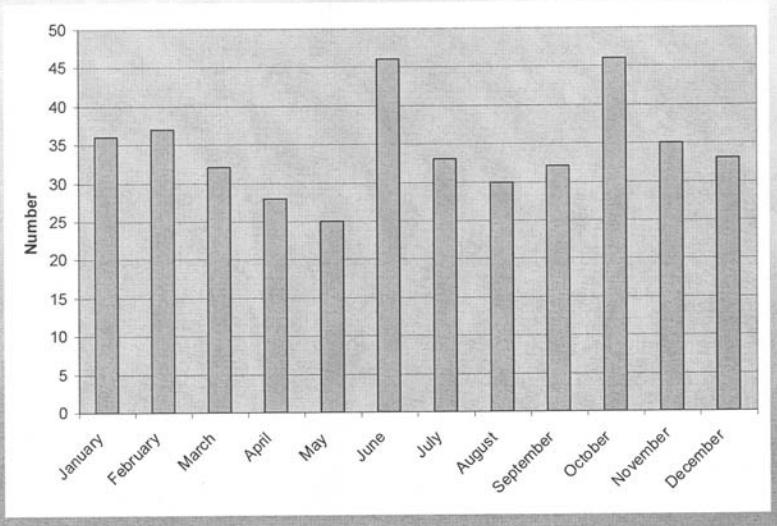


Figure 2.5: Suicide Rate by Region, Alaska 2003-2005



Suicide Count, by Month, Alaska, 2003-2005



Frequent Suicide Characteristics, Alaska, 2004-2005

Weapon/Mechanism:

•Methods of suicide were identified in 98% of all cases, where--

- 63% are committed with a firearm
- 21% by hanging
- 13% by poisoning

Circumstances:

- 50% alcohol use and drug abuse
- 45% crisis in preceding two weeks (40% with depression)
- 60% seniors (65 years and older) with physical health problem
- 34% disclosed their intent
- 29% victims left a note

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Inupiat youth suicide and culture loss: Changing community conversations for prevention

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Abstract

Inupiat living in Northwest Alaska have one of the highest youth suicide rates in the world. Other circumpolar peoples share this disturbing distinction. This demographic and ethnic health disparity has spurred research that investigates acculturation stress as a cause of Inuit youth suicide. Despite this body of knowledge, few studies describe how local people connect suicide to culture loss, even though this understanding is crucial for developing effective prevention and intervention strategies. This article describes how Inupiat understand and talk about youth suicide and suicide prevention within public settings. I have used participatory action research (PAR) to illuminate the meanings and processes that surround youth suicide. In meetings focused on suicide prevention, local people clearly link self-destruction with historical oppression, loss of the Inupiaq culture and current manifestations of these realities in alcoholism, abuse and neglect. This narrative typically focuses on young people and the Inupiaq community's current failure to lead them to a bright future. The article describes these understandings and offers suggestions to expand them in order to create new possibilities for community-based prevention and the promotion of wellness in circumpolar communities.
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Introduction

Native peoples—especially youth—living in circumpolar areas suffer disproportionately from suicide (Leenaars, Anawak, & Taparti, 1998; Misfeldt & Senderovitz, 1989; Sakinofsky, 1998; Tester & McNicoll, 2004). This demographic holds true for Alaska Natives. In statewide comparative studies, Alaskan youth suicide rates are notably higher than the rates in the other 49 states (Foulks, 1980; Gessner, 1997; Kettl & Bixler, 1991; Travis, 1983). Alaska Natives between the ages of 15 and 19 have a suicide rate of 110 (Statewide Suicide Prevention Council, 2004) while the national average for this age group is less than 20 per 100,000 (National Institute of Mental Health, 1997).

Injury surveillance from Northwest Alaska (unpublished Maniilaq Injury Prevention data, 2002) indicates that this remote region is even more dramatically affected by suicide. This Northwestern area, above the Arctic Circle, is the size of Indiana and is populated by approximately 8000 people, of whom over 7000 are Inupiat, an Inuit people. In this region, Inupiat youth, aged 15–19, have a suicide rate of 185 per 100,000 (10 year average). This is more than twice the rate for all ages in Northwest Alaska (71.4) and nearly 16 times higher than the

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rate for the nation as a whole (11.6). These youth suicide rates are similar for Inuit living throughout the circumpolar north (Leenaars et al., 1998; Misfeldt & Senderovitz, 1989; Sakinofsky, 1998; Tester & McNicoll, 2004).

To explain this glaring health disparity, many researchers point to social disintegration and acculturation stress brought on by rapid social, economic and cultural change (e.g. Berry, 1985; Jilek-Aall, 1988; Kettl & Bixler, 1991; Kirmayer, Fletcher, & Boothroyd, 1998; Larsen, 1992). Tester and McNicoll (2004) link suicide to the ongoing and systematic abuse of the Inuit, but few other Arctic suicide researchers make this explicit. Thorslund (1990) examines the demographics of suicide and notes the social problems surrounding these events. He also considers the historical context for suicide in Arctic cultures. The act of suicide seems historically to be associated with infirmed individuals, but youth suicide has been noted since the 1960s in Greenland, Alaska and Canada (Chance, 1990; Hippler, 1968; Larsen, 1992; Thorslund, 1990). Results from a Danish nationwide questionnaire survey of Inuit youth indicate that "few [young people] see suicide as a sign of psychiatric disease and that the majority interpret suicide as a regrettable reaction towards some common problems of life" (Thorslund, 1992, p. 152). This social acceptance is believed to "ease the transition from suicidal thoughts to suicidal action" (Thorslund, 1992, p. 152).

Larsen (1992) expands this view to consider the role of alcohol in Inuit suicide. Etiological suicide research shows that alcohol consumption can be implicated in most Inuit suicides (Foulks & Klausner, 1981; Gessner, 1997; Kettl & Bixler, 1991). Larsen (1992, p. 136) believes this is because "a 'wild' drinking style increases the probability that alcohol consumption will lead to aggressive behavior". This assertion has also been made by others (Foulks, 1973; Foulks & Klausner, 1981), who contend that drunkenness is considered to be a valid excuse for breaking social rules. These scholars note that Inuit rituals associated with "being out of control" such as *losing one's soul* are currently associated with drinking episodes. In these episodes, individuals are released from social sanction and are allowed to act in "inappropriate" ways. Many times this—along with pent-up aggression—results in violence directed at oneself or others.

The disruption in gender roles is also posited to have contributed to the high rates of Inuit male suicide. The male role has traditionally focused on hunting and fishing subsistence activities, but because of a decline in these, displays of gender differentiation are frustrated. Larsen (1992) asserts that cultures which emphasize the masculine role tend to increase the probability of male aggression. By stating this, Larsen is drawing from Segall's (1988) conception of *compensatory machoism*. This term has been used to describe aggressive *gender-marking* within a culture. Inuit culture fulfills the conditions for creating compensatory machoism because there is a sharp division of labor between the sexes: women do primary childcare and men do subsistence hunting. The opportunity to have physical displays of gender differentiation is limited by a decrease in the sanctioned violence of hunting and the Inuit value of non-violence in community settings. This situation is thought to lead to pent-up feelings of aggression because men do not have opportunities to release them. Larsen (1992) posits that compensatory machoism, alcohol consumption and the Inuit norm favoring non-aggressive behavior combine to create a dangerous situation that results in more impulsive, violent death.

Local people in Northwest Alaska point to similar culprits in explaining suicide. Alcohol abuse, lack of community controls and loss of traditional roles are typically implicated in the tragedy. To better understand how these linkages are articulated and understood by community members, this paper will describe the public narratives related to suicide and suicide prevention. Drawing on field notes, focus groups, community discussions and interviews conducted over the course of a 2-year participatory action research project aimed at preventing suicide in Northwest Alaska, this article will describe the dominant explanations of Inupiat youth suicide and ideas for prevention.

The resulting narrative is ethnographic, in that it is holistic, contextual and reflexive (Boyle, 1994). It, like other ethnographies, attempts to assemble a cohesive story that makes sense out of everyday life. In doing so, *my* conception of the whole story guides these results. According to Bruner (1986, p. 141), "the past, present and future are not only constructed but connected in a linear sequence that is defined by systematic if not causal relations. How we depict any one segment of the sequence is related to our conception of the whole...". As the Suicide Prevention Coordinator for the region during the study, I tried to link the meanings of suicide to frameworks for action. This paper will then explain

how these understandings affect individual agency and a sense of collective purpose regarding suicide prevention and health promotion. Suggestions for fostering these within the current meaning systems will be explored in order to make community-based suicide prevention efforts more meaningful and effective.

Methods

This paper uses a participatory action research (PAR) design to illuminate the meanings and processes that surround youth suicide. PAR has been used successfully to engage Native people in community-level health interventions (Best et al., 2003; Dickson & Green, 2001; Fisher & Ball, 2003; Mohatt et al., 2004). Via this approach, etiological suicide information along with interview, focus group and survey data was shared with community members iteratively over the 2-year study in order to develop village plans and foster community-based action focused on suicide prevention and wellness.

This work relied heavily on a Regional Suicide Prevention Taskforce made up of community members from each of the region's 12 villages. Taskforce members agreed to analyze local suicide data so that they could design village-based prevention initiatives. The taskforce held quarterly meetings from March 2001 to October 2002 with approximately 30 members attending each session. To document discussions, meeting notes were taken by my Native colleagues and myself at each meeting. All the other documents (flip chart notes, writing exercises, worksheets, etc.) generated in the meetings were put into the notes.

PAR can be differentiated from other methods by its collaborative approach, an aspect vitally important to Native communities (Best et al, 2003; Fisher & Ball, 2003). Community involvement requires some flexibility in the research process. In this case, the taskforce and other community members demanded that I not only conduct research, but also educate them about suicide and provide prevention services to their children. Because of this expectation, I spent the vast majority of my time doing suicide prevention education and outreach in the 12 villages of the region. My classes, trainings and organizational meetings became my main platform for critical dialogue with youth and adults in village communities. The notes I took during and after these encounters were a dominant data source. Along with these notes, my writing documented the ways that suicide was talked about and responded to in everyday life.

Field notes tracked my experiences, documented my thoughts and helped me formulate ideas to discuss with my native colleagues—the project's community coordinator and individual taskforce members who served as key informants. They served as my dialogic partners and cultural "translators" because they were willing to struggle with their *paradox of familiarity* (e.g. Kendal, 1989; Ochs & Schieffelin, 1984). The paradox of familiarity refers to participants' over-familiarity with their own cultural practices, which makes them unable to articulate or identify internal patterns. In an ongoing manner, I sought insight from local people. They helped me apply "reality checks" to my critical reflection. The process also offered my colleagues ample opportunities to influence the direction of my analyses.

In addition to field notes and taskforce meetings documents, I conducted focus groups with young Inupiat to augment my understanding of youth suicide from a youth perspective. Focus groups ranged in size from 3 to 12 participants and all respondents were between the ages of 13 and 21. Brenda Goodwin, the project's Inupiaq Community Coordinator, and I conducted sessions in every village in the region. Quotes from these sessions were used as *generative themes* (Freire, 1970) in the last two quarterly taskforce meetings.

Most of the focus groups were transcribed, edited and coded after I moved out of the region. I listened to the tapes, typed what I heard and wrote memos to track my thoughts throughout the process. After inputting the data, my next task involved coding the transcript. I developed the codes as I went, paying attention to the focus of the study. Once all of the focus groups were transcribed and coded, I read the transcripts again to check the accuracy of the codes and to insert memos. These data were combined with the field notes, minutes from community engagements, social artifacts and the survey results to inform the final narrative.

This paper focuses on how people make sense of youth suicide. It is this process of meaning-making that situates people's parameters for action. The trajectory of suicide does not have a definite beginning and end; suicide narratives are "cut from the stream of temporality" (Turner, 1986, p. 35) based on people's beliefs, suppositions and expectations. These structures of meaning are connected to patterns of action and inaction found in Inupiat

villages. Instead of suicide being emblematic of collective helplessness, despondency and/or cultural demise, suicide prevention can facilitate a communal response by eliciting a shared conviction that something can, in fact, be done. This latter interpretation can galvanize community members to collectively craft a promising future. In this way, understanding and communicating about how suicide is interpreted within the local community has profound implications for community health.

Inupiat link suicide to culture loss and current failings

The story begins by describing the dominant narratives used to structure community conversations about suicide prevention. In community meetings, it is easy to trace the pattern of historical trauma, racist policies and drastic change that has led Inupiat youth to choose death over life. Public speeches denounce past treatment at the hands of missionary school teachers, government policies that kidnapped Inupiat children and sent them away, official requirements that made seasonal migrations obsolete and modern conveniences that thwarted cultural pride. In this rhetorical strand, colonization is considered a relic, something from the past that still holds meaning but is somewhat obsolete.

The drawback of this way of thinking for young people is that "the enemy" is no longer obvious. Colonization is embedded in the fabric of everyday life, so much so that local people do not even consciously notice its current forms. It is believed that young people are quietly preyed upon by unnamed forces *caused* by colonization but currently *perpetuated* by Inupiat. It is this rhetoric that calls each Inupiaq to take action and fight cultural attrition, community disintegration and personal failure, but no one knows how to proceed. Because of this, the rallying cry loses conviction in everyday life. In the next few paragraphs, I will illustrate how suicide and suicide prevention—as ideas—are talked about by local people throughout the region. This will be the basis for a discussion about how to make the dialogue empowering in everyday life.

The following excerpt is taken from a regional conference entitled *ELDERS & YOUTH: Suicide/ Substance Abuse Prevention: Elders' Wisdom Guiding Us into the New Millennium*. It frames the public discussion of suicide in Northwest Alaska. The words were read by a respected elder, Levi, and a thriving, Inupiaq youth, Tiffany, at the Annual meeting of the Native, non-profit health organization. The keynote speech had support from community leaders, who approved it before the gathering. The conference was attended by representatives from all of the region's villages and held in a community building in the region's hub city (Kotzebue) on January 31, 2001. Excerpts from this oration highlight the matrix of issues connected to suicide when it is spoken of in public spaces. The speech was printed and distributed to all attendees.

> LEVI: (In Inupiaq first) Yes Qaayaan, it's only been in the last 30 years or so that we have seen our lives change so drastically. Before we had electricity, running water, snow-go's, and all those other things which have made our lives easier, every working hour of the day was spent on survival tasks. We had dog teams to take care of, water and ice to get, firewood to collect, and our hunting and fishing activities took a lot more time to travel to where the fish and game were...
>
> (Then Levi translates to English.)
>
> TIFFANY: As young people, it has been hard for us to understand our role today. Most of us do not speak or even understand our Inupiaq language, so we don't communicate well with our parents and grandparents. On top of that, we have so much idle time due to the lack of jobs in our villages, most of us don't have to worry about getting water, wood, taking care of dogs, and getting caribou and fish and other subsistence foods takes a lot less time now.
>
> We go through twelve years of school, but most of us aren't prepared to succeed in college or other training, and therefore the many jobs in the region are not filled by people from here.
>
> (Tiffany's comments are translated into Inupiaq).
>
> LEVI: (Again in Inupiaq first) I agree, we haven't come together in our villages to help our young people understand what their place and purpose is. As a result of not knowing what to do, many turn to alcohol and drugs to feel good and because we hear youth say there's nothing else to do.
>
> TIFFANY: Yes Levi, we need to have our parents and other community members become more involved in our young people's lives. I want to go back to what I was talking about earlier about going through school for 12 years and graduating into what seems like no future. After a few years of that, life doesn't seem attractive.

We need and want to be prepared for the world WE will live in.

Many of our young people get depressed.

(Tiffany's comments are translated into Inupiaq).

LEVI: (Again first in Inupiaq) Yes, and we also need to understand that many times we feel like we are losing control over our own lives. Up until 1976, our kids were sent away to boarding schools, and even before that, when the schools were set up in our communities, our children were told not to speak their Inupiaq language. So we had a situation of our kids being raised by someone else in boarding schools, being told not to speak to our children in our own language, not to Eskimo dance, and we had spirituality in a different way.

So, over time, we have felt like our ability to control our own lives has been taken away. Our children are not able to communicate with us, our lives being very different through the changes that have occurred, our constant battles with trying to protect our subsistence way of life, to our young people not feeling like there's a future for them. We haven't replaced these things with an understanding of how to have healthy villages.

(LEVI then reads the above in English).

TIFFANY: No wonder people turned to alcohol and drugs. But it's time now for us to know we have the knowledge to be in control of our lives. That each one of us as individuals can begin changing how we see things now.

The excerpt starts with a historical perspective that emphasizes the wellness of the past and places it in stark contrast to the struggles of present-day youth.

Youth are brought up with reminders of difference between then and now. Young people are taught to revere the past and to appreciate their parents' hardships. This sentiment is voiced in Inupiaq Days at the region's schools, community gatherings and at the three area summer camps where "culture" is discussed. The hard work of their parents' generation is often contrasted with the ease of modern living. This is intended to make young people aware of their privileges and to foster appreciation and respect for Elders. Young men in a focus group talk about how this perspective is passed down.

Joe: They'd sit us down and talk to us (about) ...how hard they had it when they were growing up and how easy it is for us. I mean, they...my dad had it hard...

Eli: They didn't have running water and all that sort of stuff. No light bulbs.

Joe: They didn't even have a high school. They just had an elementary.

Eli: They had to go out to [boarding high school] to get, to further your education.

Joe: And some of our parents were, were kicked out, literally kicked out [of the village] to go to high school when they didn't have a say in it. They just had, had to go.

Tales of past abuse and hardship are common. Young people in all of the focus groups mention their legacy of oppression. This conception of injustice binds them to the past and puts their privilege and freedom in sharp contrast. How is this advantage internalized in a community where hardship is a badge of honor? The *concepts* of "Elders" and "ancestors" are permeated with notions of strength, hard work and the ability to overcome imposed separation adversity.

In contrast, youth are seen as weak, unable to succeed in either world—Inupiat or Naluagmiu.[1] Sarah, a middle-aged Native woman pulled me aside to explain this situation after I presented information on suicide and suicide prevention in a well-attended training. She said,

[We] went from being an independent people, to getting lots of free stuff...break their spirit. I'm one of those that had a lot of suicides in our family. I've lost lots of cousins...They don't have enough motivation, no they do. They just don't have enough self-esteem to go out there and make a fire. Even a 20 year old has someone cut wood for them—elders cut wood for young people!

Community members generally believe that failure is not young people's fault. Young people's lives are too easy, a situation which has weakened their strength, atrophied their spirit. Youth do not even practice the rudiments of traditional living.

Hard work bridges the gap connecting the past to present. It is the backbone of Inupiaq culture. Hard work is even cited as one of the 15 core Inupiaq values (Ilitqusait) in the official publication authored by the Regional Elder's Council in 1976. In the Inupiat Ilitqusiat text, *hard work* is

[1]Naluagmiu is the Inupiaq word for White Person.

sandwiched between the values of *cooperation* and *respect for elders* for good reason. Elders had knowledge needed for young people's survival, whereas youth were best able to accomplish tasks that required strength. This interdependence created a web of support between and within family groups. With modern life, Elders' knowledge is outdated, and hard work is no longer necessary.

Without practical anchors to the past, Inupiat people, men especially, have drifted into meaninglessness. In a public meeting about suicide, Mike, a long-time resident, explains at a suicide prevention meeting, "Elders said that a long time ago, it just wasn't suicides...They were too busy being with family, chopping wood. In this day and age, it's just not happening anymore. Also, young men knew their place and had definite roles to play in their communities". At that same meeting, a Native man asked,

> What is left for those to feel like a man? They were traditionally the caretakers of the family, now things are really changing. They no longer feel like they are caring for their families. Subsistence is really important for men to feel like they are contributing. It gives them a place.

Unfortunately, even subsistence activities require snowmobiles or boats in addition to gas money, and many men are unemployed.

Inupiat men are expected to support their families, but the wage economy that is available in the villages is not well suited for Inupiat masculine roles. Most of these jobs are office-bound, and desk jobs are believed to be for women. Many local people lament the loss of men's role in the community. "People round here look to women for strength when it should be the men", Ethel complained at a women's gathering, continuing, "The roles are reversed from women being at home to men. I feel like the burden always fall on us." In a different meeting, a long-time resident said, "I have noticed when I visit people's homes that young men are at home taking care of young children. The women are off working because the family needs an income. I see a lot of frustrated young men."

Without a masculine role to play in the village, young Inupiat (men especially) are lost and *bored*. In an open-ended survey given to 382 people in the region, Native adults cited boredom more often than anything else as the reason for youth suicide. The survey question asked, "Why do you think young people in this region attempt or commit suicide?" In response, adults wrote things like, "Young people are always saying they're bored, have nothing to do." Or "Lack of things to do. Lack of purpose or a feeling of purpose." In this sense, youth boredom translates to meaninglessness, cultural attrition and lack of social role.

Although these problems stem from colonization, many community members believe that youth boredom, suicide and other bad outcomes are currently their own fault. "Youth problems" underscore Inupiat adults' impotence and their community's disintegration. Edna, an Inupiaq Elder, called me one day to vent her frustration. She describes the situation as follows:

> Teenagers right now have no respect for Elders. As a community, they don't work as one. They just look at each other and talk bad about each others. Not being unity. You need the whole community to make things work...The biggest problem (is that) (the community) don't want to get involved!

Edna and many others believe that the community spirit is broken. At most meetings focused on suicide prevention, speakers bemoan their communities' lacking. "People don't turn in bootleggers (people who import alcohol to dry communities), even though they know who they are." "Parents let their children push them around." "Community members look the other way instead of getting involved in other people's issues." Without community involvement, it is no wonder that children are "out of control".

Inupiat in the region believe that youth commit crimes, disrespect others and kill themselves because adults "let them". Enok, an Inupiaq Elder, gave this speech at a regional Elder's conference explaining the situation. He said, "(We) used to have rope to hold doors from banging around. Now we have strongest locks and they are broken. We let go of our children—let someone else raise them, let the teachers raise them." Without guidance, young people ignore their communal responsibilities and turn against their fellow villagers and themselves. At a regional conference, Sherman, an Inupiaq Elder, summed up the situation by saying, "They found a void between the Elders and the youth, which is probably why suicide is happening more."

This kind of speech is typical. In public meetings, the gap between the generations is often linked to government policies that separated families and forced young people to attend high school in

another region of the state. Billy, a well-educated middle-aged Inupiaq, illustrates how this story is generally told in the region.

> Our young people were gone—off to boarding schools. The government against the Inupiaq language made us not be able to communicate with our Elders. Parents in this region thought someone else raising their kids in boarding schools was the best thing for their kids.

Since someone else raised them, it is believed that today's Inupiat grandparents and parents do not know how to raise their own children. LuLu, a middle-aged Inupiaq, identified the following parental failings in a community meeting focused on suicide prevention. She said, "I see a lot of neglect—parents work all week and then go to bingo. They aren't spending enough time with their kids." Many young people shared this sentiment in focus groups throughout the region. In one of these group discussions, Archie explains this common perspective: "I think if parents and grandparents were a lot more involved with their kids and their grandkids, then they wouldn't have to commit suicide...". Because no one is showing them the right way to be in the world, young Inupiat are faced with "no future".

Inupiat youth suicide is tragic on a personal and communal level. Not only are young people dying, their death signals the destruction of the Inupiat people. Parents, Elders and other Inupiat people are called upon to stop the destruction of their children. This call is regarded as a moral and cultural duty. Bertha, a well-educated, middle-aged Inupiaq, speaks of this Inupiaq obligation in a mass e-mail sent out to the entire region.

> We need to remember only the strong will survive and those of us who neglect ourselves, sadly to say our children will not be strong enough... We need to discipline ourselves to be healthy and take part to start a new legacy of a healthy Inupiaq generation. We need to stop taking chances with our race and take charge for our children and their children's sake. The way we are going and neglecting and abusing ourselves, how can we act like nothing is wrong?

Bertha's pointed question, "how can we act like nothing is wrong?" is asked in different ways by community members in virtually every public meeting I attended during the 2-year project. It seems that even though many people call for and attend meetings focused on stopping substance abuse and preventing suicide, there is still a pervasive feeling of despondency, as though people go to meetings *instead* of taking effective action.

Most conferences begin with hours of presentations that identify problems in the region's villages. Statistics about child abuse, alcoholism, teen pregnancy, high school dropouts, sexual assault and suicide highlight the ways in which community members are failing themselves and their children. A village leader exclaimed at one of these meetings, "If we were a well community, then we wouldn't have these statistics." In sharing this evidence of "un-wellness", these meetings reify people's sense of doom and contribute to people's collective despondency. Although hundreds of hours are spent every year talking about prevention, very little happens in village communities afterward. Many people in the region point to this as evidence of the community's lack of concern and laziness.

The public rhetoric concerning suicide implicates cultural oppression of the past while also highlighting the failure of modern Inupiat to lead their children to a promising future. In short, the process started with colonization but is believed to be currently perpetuated by Inupiaq "neglect", "abuse" and apathy. In this way, community discussions about suicide are about village and family deficiency—suicide is a "lack of"—that is emphasized by collective inaction. Eve, a middle-aged Inupiaq who lost her son to suicide and was an active member of the taskforce, complained at a poorly attended meeting, "Suicide is a huge problem! Where is everybody? It's kinda hard when you feel like you are fighting the whole thing by yourself." To answer her own question about the lack of attendance, Eve said a few minutes later, "People don't know what to do. If we knew, we would do it." Suicide prevention is therefore an urgent call for community action without a clear direction.

Using community meanings to build universal suicide prevention strategies

For Inupiat living in small villages, suicide is both personal and communal, an individual act and a social one. Instead of dying by intentional "accident", suicide makes clear the person's intent. With this knowledge comes a different sort of introspection for families, friends and communities. People generally got involved in suicide prevention

meetings because they were survivors and wanted to "do something" by taking a public stand against suicide.

Even as they committed themselves to the public effort, many wondered if suicide prevention was possible given the scope and depth of the problem. At the first Suicide Taskforce meeting, participants were asked to write down their hopes and fears for the project. The following fear seems to touch at the core of the issue. A taskforce member wrote in sprawling letters on his 3 × 5 card: "FEAR: That this problem is bigger than us. That suicides will continue. I feel we are 'victims' of progress and it is difficult to cope with the problems of today." If suicide is a response to colonization, modernization and the resultant community failings, what is there to be done?

First, it is important to change this dialogue. Cultural oppression is the cornerstone of Inupiaq discourse about suicide, but instead of facilitating collective and personal agency, it fosters despondency. In public forums, community leaders note the contrast between the current problems in the villages and wellness of the past. The trouble is that by focusing on the past, people rarely look for current, more subtle manifestations of colonization that exist today. Many Inupiat assume that oppression ceased when the white people in power stopped their *overtly* racist policies and practices. This assumption ignores the lived experience of oppression. In subtle, yet ubiquitous ways, Native people are forced into Western paradigms. This subtlety renders modern colonization invisible or ambiguous. "Ambiguity has serious consequences when a people are told that they live in an egalitarian society but find that their every action or feeling, indeed their very being, is highlighted as inferior, different, and of less importance" (Tatz, 2001, p. 7). Instead of having a clear enemy, Inupiat internalize their failures and blame only themselves.

Young Natives especially feel this tension as they try to live in and across both worlds (Kasten, 1992). For example, Inupiat youth are expected to (and want to) "succeed" by graduating from high school, but schools are Western institutions that require individuals to adhere to Western ways (Wax, Wax, & Dumont, 1989; Wexler, 2006). This is often obscured by the local schools well-intentioned deference to Inupiaq culture. An Inupiaq high school student explains this ambiguity by contrasting Anchorage schools to those in the region's villages.

> I mean here you can learn to talk Eskimo and like in Anchorage it's hard cause there, they teach you French, they teach you German and Spanish, but they don't teach you Inupiaq. It's weird they don't teach you the traditional stuff. I mean, it's more of a White man's place to live. I mean, it's the same here but I think it is better here because you can learn your Eskimo words and grow up with your grandparents.

Although modern schools in the region try to be respectful by integrating Inupiaq activities and language into the school day, they—as institutions—cannot help but impose Western standards on young people. The language used in school (Standard English) is different from vernacular "village English" most community members use, so young people are being educated to *be* different from their community. The standardized tests, organization of time and the individualistic reward system of schools reflect Western assumptions and values (McLean, 1997). In addition, schools carry a dark history of language stealing, community and family subjugation, and cultural repression that is recounted in many public forums. As one middle-aged man stated in a meeting focused on young people; "We don't like to name our predators. The school system is one of them—they are taking our young people's minds and turning them against us." It is no wonder that many parents are ambivalent about their children spending so much of their time there.

With the tension of divergent expectations and without full support from many Inupiaq families, some young Inupiat "lose interest" in school before graduating. This has been well-documented in other Native populations (Deyhle, 1989; Fordham, 1996). These "dropouts" still want to succeed in "the (Western) world", but have not gained the skills to do so. Their failing is understood as a personal failure, not an institutional one, i.e. not the failing of the schools. The following focus group excerpt provides an apt illustration of the personalization of failure and its implications. Roger, an Inupiaq, said:

> To this day, I never thought I would be drinking at the age of 18. I never thought I'd be doing anything but going to school, finishing high school and going to college or something. But, now that, you know, I have done wrong like a whole bunch of things, now I look at my future, and (wonder)..."

Typically, success is located in Western accomplishments (e.g. finishing high school). When Inupiat fail to succeed in these forums, they link the failure to personal and collective lacking (e.g. doing wrong). This is itself a form of oppression because responsibility (and guilt) is placed on individuals who have little control over the institutional or structural frames that increase the likelihood of their failure. This leaves them without clear avenues for success and few possibilities for the future. Thus, blindness to current forms of oppression perpetuates individual and collective subjugation which can lead to a pervasive feeling of hopelessness.

To foster new awareness and a sense of agency, oppression must be re-conceptualized as a modern phenomenon with historical roots. This perspective honors the generational grief talked about in public forums, but moves toward personal agency and community healing. Understanding how colonization began and *continues* today puts the villages' problems into historical context and provides youth with concepts to better understand and respond to their experiences. This can be an insightful and useful process. Janie, a middle-aged Inupiaq woman, told me about how this kind of awareness helped her gain strength and make positive changes in her life.

> Janie had suffered from depression for a long time and was really "strict" with her children, which probably meant physically abusive. She then asked God for help and she prayed. Soon after, she was given a book that told her the history of her people. She said that the history made her understand why she was the way she was. That book gave her strength to change, and she did. She stopped drinking and was "nicer" to her children.

As Janie's story illustrates, understanding the historical legacy of colonization can be important for re-conceptualizing the present and designing a brighter future. This has been found to be true for other Native populations (Brave Heart-Jordan & Debruyn, 1995; Duran & Duran, 1995).

Native people must be able to trace the colonization of the past into the present day. This kind of *cultural literacy* allows Inupiat, youth especially, to identify modern forms of oppression and find ways to respond to it. This, in itself, can be empowering on collective and personal levels. Noticing colonizing structures puts that which is Inupiat in stark contrast. This perspective offers individuals a platform to re-conceptualize themselves as Inupiat and evokes a collective purpose: to resist colonization. In this way, awareness of current forms of oppression can facilitate Inupiat cohesion along with the personal agency to construct meaningful social realities (O'Neil, 1986). Many cultural groups have developed pride and strength in their collective resistance, with real consequences for individual and collective well-being (Brave Heart-Jordan & Debruyn, 1995; Chandler & Lalonde, 1998; Duran & Duran, 1995).

Reading the world this way and acting on that reading can provide Inupiat youth with new ways to think about and to "own" their lived culture. Instead of "Inupiaq culture" being primarily about the "old ways" (as many youth believe), youth in this way could devise new ways of valuing the current meanings and practices of the Inupiat, while also reinterpreting traditional ways. Culture is not static—meanings, symbols, beliefs are recreated by each new generation as they meet everyday life-world realities. Inupiat youth in Northwest Alaska have not been encouraged and supported in this reinterpretation. They talk about their lack of cultural knowledge, their inability to speak Inupiaq, and even their dislike for traditional foods as evidence of their alienation from their cultural heritage. Young people believe Inupiaq culture is connected to the skills, food and language *of the past*. With this conceptualization, how do young people know they are Inupiat?

This important question must be put into reflection and conversation among young people, their parents, uncles, aunties and grandparents. Answering this central question with the help of Inupiat adults will be the very revitalization process they and the Inupiat people need if they are to craft personal and communal identities which have more real meaning and are more pregnant with action possibilities. Continuity between past and present is lived, as is culture, thus removing culture from history and locating it in everyday life. Increased *cultural continuity* (Chandler & Lalonde, 1998) invites communal care and concern for both a shared past and a collective future. Research shows cultural continuity to be a powerful deterrent to suicide (Chandler & Lalonde, 1998; Chandler, Lalonde, Sokol, & Hallett, 2003; Kirmayer, Brass, & Tait, 2000; Middlebrook, LeMaster, Beals, Novins, & Manson, 2001).

By making modern forms of colonization visible and investigating how Inupiaq culture exists today,

Inupiat can marshal the moral agency to withstand and resist oppressive structures. These enterprises invite Inupiat to craft a collective identity through constructive social action. This also provides a platform for young and old to construct their own political and social context. Through collective resistance and cultural re-creation, Inupiat can meet the moral and cultural mandate of suicide prevention, and in so doing, create a sense of Inupiaq unity to take into the future.

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Gatekeeper

Suicide Prevention Training

A *gatekeeper* is anyone within a community who is responsible for the health and safety of an individual, has access to resources, and has the ability to listen, connect, assess, and most importantly, act when someone is contemplating suicide. The Alaska Gatekeeper Training will help prepare and give knowledge about suicide, including identifying risk factors, warning signs as well as protective factors that influence a person's ability to care for themselves during a crisis. Gatekeepers will also learn and practice intervention skills such as active listening, relationship building, assessment of risk, and the development of an action plan including the identification of community resources and making appropriate referral. The *gatekeeper* is just that-someone who keeps watch and identifies, but does not treat in the long term.

The objectives of this training are to:

1. Learn about the prevalence, research, myths and facts surrounding suicide.
2. Teach people how to become good listeners and give a concerned response to a suicidal individual.
3. Teach people how to feel comfortable and effective as gatekeepers who listen and assess.
4. Develop a group of people who are comfortable intervening with individuals who have suicidal thoughts, or are about to engage in self harm.

The Targeted Gatekeeper Training and the Targeted Gatekeeper Program was developed at the University of Alaska Anchorage, by staff of Behavioral Health Research and Services (BHRS) and with the support from many community volunteers. During the development, ***no single set of standards of care has been identified as the answer to all suicide assessment and prevention efforts***. Each contact with a suicidal person is unique and the outcomes of a gatekeeper interaction cannot be predicted with certainty. This gatekeeper training simply provides guidelines, information and skills training to prepare gatekeepers clinically and ethically.

For more information about this training or how to arrange the Targeted Gatekeeper Training to be conducted in your community or agency, please contact James Gallanos, LCSW, Department of Health and Social Services, Behavioral Health, Office of Prevention and Early Intervention Services, (907) 465-8536.

"THIS PROGRAM IS APPROVED BY THE NATIONAL ASSOCIATION OF SOCIAL WORKERS (PROVIDER #886487947) FOR 9 CONTINUING EDUCATION CONTACT HOURS."

Project Life is a three-year (2006-2009) youth suicide prevention program that is part of Maniilaq Behavioral Health Services. It is funded through appropriations under the Garrett Lee Smith Memorial Act for youth suicide prevention, and administrated through SAMHSA (Substance Abuse and Mental Health Services Administration). Maniilaq Association has made suicide prevention a top priority.

We view suicide as a symptom of lack of wellbeing and we intend to reduce this symptom by promoting holistic wellness through knowing and living *Iñupiat* values.

Iñupiat Ilitqusiat presents a cultural wisdom that is not compatible with suicide. If *Iñupiat* Ilitqusiat is understood, internalized, and lived, the cause of suicide and other symptoms of a lack of wellness will naturally decrease.

Project Life was fully staffed (3 people) on November 20, 2006.

The overall goal of Project Life (PL) is to facilitate a decrease in the number of suicides and suicide attempts, through a variety of interventions:

1. Project Life will create a media campaign that emphasizes positive aspects of life and living Inupiaq values. The campaign will also stress that suicide is not a normal or inevitable response to life stressors. Creation of the campaign will be collaboration between Project Life staff and community members, who will contribute artwork, photographs, voice recordings, etc. The media campaign will be presented on the radio, internet, and in print publications.

    - A list of positive messages about life was created to be used in combination with visual media, such as posters and calendars, as part of the media campaign. Visual art will be solicited from the communities to use in combination with the positive life messages as part of the media campaign. The messages emphasize life and Inupiaq Ilitqusiat (values).
    - Project Life held a logo contest, soliciting entries from youth in the region. The entries were combined into a large poster that was hung at the Kotzebue Post Office for a "peoples vote" to select the winner. The winning logo was used in the Project Life pamphlet.
    - Project Life staff created a Project Life pamphlet introducing and describing the Project Life program. The pamphlet summarized the basic philosophy of the program: "Promoting holistic health through Inupiat Ilitqusiat; wellness of the whole person will reduce the causes of suicide." The pamphlet also presented the winning artwork from the logo contest, staff contact information and brief bios, a picture of staff, a summary of program activities, and a visual symbol representing the holistic model of human beings. The pamphlet also featured Inupiat language as part of the design.
    - 3 articles about Project Life have appeared in the Maniilaq newspaper, Sivutmuuluta.

- Construction of the Project Life website has begun in-house with the help of Maniilaq media staff.
- Radio public service announcements (PSA) were aired regularly (and continue to be aired) on the only local radio station KOTZ, which is broadcast in Kotzebue and all the surrounding villages. These PSAs consist of recordings made by Project Life staff of various community members stating their name, village, and activities they enjoy, and ending with the statement, "I enjoy life." Project Life staff also created a PSA announcing the start of the suicide screening that would begin at Maniilaq Health Center. This PSA gave people examples of the kinds of questions they might be asked. This was done to prepare the community for the new screening. Also on the radio, the station manger interviewed Project Life Manager and Educator about the Project Life Program and suicide prevention.

2. Project Life will promote cultural continuity and resilience of Inupiaq youth through educational classes (life skills, communication skills, interpersonal skills, coping skills, self-care) and facilitating the creation of digital stories. The telling of individual stories will help foster a sense of cultural continuity, identity, and help motivate communities towards collective cultural wellbeing. Project Life will also promote the strengthening of meaningful relationships between Inupiaq youth and elders, and Project Life has made elder collaboration a top priority.

    - Between January and September 2007 Project Life manger made 19 trips to the following villages: Noorvik (3 visits), Kiana (3 visits), Kobuk (4 visits), Shungnak (2 visits), Buckland, Deering (2 visits), Kivalina, Ambler (2 visits), and Pt. Hope. Project Life Educator made 19 trips to the following villages: Noorvik (3 visits), Kiana (2 visits), Noatak, Selawik, Kobuk (4 visits), Shungnak (2 visits), Buckland, Deering (2 visits), Kivalina, Ambler, and Pt. Hope. Each visit has been 2-5 days in length.

    - The emphasis of the first trips was to visit with Elders and community leaders (i.e. school principals, mayors, community health aids (CHAP) at village clinics), to build relationships, introduce Project Life, and facilitate community buy-in to the program. Working in small native villages requires cultural awareness, knowledge and skills. We are building a foundation of support so that we are welcome to continue returning to the villages, and engage community members in grass roots suicide prevention activities that are sustainable by the community. The autonomy of the villages must be respected, and how we approach these communities is very important. If we are perceived as another outside, western program coming into the village to tell them what to do, or to fix things, it will not work, and we will not be welcome to return.

After the initial visits, trips were made to participate in a regional softball tournament involving hundreds of youth from the region, and Elder/youth culture camps. After school started (September 2007) classes and workshops began in the village schools with a week spent each in Kobuk, Deering, Shungnak, and Kiana. These week long visits will continue as staff makes their way to all the villages throughout the school year.

- Project Life staff also met with elders in Kotzebue at Elder's Committee meetings, and in our Kotzebue offices with Elder leaders.
- Project Life Educator created curriculum for suicide prevention, resilience, and life skills for grades 3-12, and met with the Northwest Arctic Borough School District (NWABSD) leadership to obtain permission and cooperation for Project Life presence in all village schools, which will begin in the fall of 2007. NWABSD leadership has been very supportive of the Project Life program, and welcomed Project Life staff and activities in the schools.
- Project Life Manager attended two trainings (10 days total) on Digital Storytelling. Software and equipment to facilitate digital storytelling workshops were purchased and these workshops will begin in the fall of 2007 and be presented in all the schools throughout the school year. Project Life staff have been informing youth in the villages about the coming digital storytelling workshops and encouraging people to prepare if they would like to participate. Preparation includes writing a rough draft of their story, gathering pictures and/or video to use in their story, and choosing music for their story. We also advertised about the digital storytelling workshops and the needed preparation in an article in the Sivutmuuluta newspaper. In addition Project Life staff have talked to many of the school principals and teachers about the digital storytelling workshops. We have also provided the NWABSD with the video editing software needed for the workshops. This software will be put on the NWABSD server for access by the students. A syllabus, resume, and transcripts were provided to Chukchi College as part of proposal to seek approval for college credit for participants in the digital storytelling workshops. Approval for college credit was granted and participants in the digital storytelling workshops may receive one unit of college credit at no cost. Project Life is providing the instructor and paying the tuition.
- Project Life manager attended the Canadian Association for Suicide Prevention (CASP) conference in Yellowknife, NW Territories, Canada, October 5-8, 2007. This conference featured many Inuit speakers.
- Project Life manager, educator, and evaluator attended the annual SAMHSA conference for Garret Lee Smith grantees in December 2006, at Bethesda, MD.

3. Project Life will provide suicide prevention/intervention trainings to youth and adults so that ordinary community members know how to recognize elevated

suicide risk, and how to respond appropriately, including appropriate referrals to professional helpers.

- Project Life staff have prepared age-appropriate suicide prevention/intervention trainings for youth and adults. Project Life Educator has prepared suicide prevention/intervention trainings for youth that will be presented in all 12 schools, grades 3-12. Participants who are minors require parental permission and the consent forms were sent to the schools in advance of the actual classes, which began in the fall 2007. The same is true regarding consent forms for the digital storytelling workshops.
- While in villages Project Life staff also offer suicide prevention trainings to any adults in the community who wish to participate. The training curriculum has been prepared and these trainings began in fall 2007.
- Youth and adults who participate in these trainings will learn to recognize signs of elevated suicide risk, what to do, what not to do, and how to make appropriate referrals to professional helpers.

4. Project Life will provide suicide prevention/intervention trainings specific to "gatekeepers" (persons and agencies that serve youth such as medical & school personnel, pastors, behavioral health employees, youth court, juvenile justice, family services staff, etc.). Project Life will facilitate the establishment of suicide prevention protocols in agencies that serve youth.

    - Suicide prevention/intervention gatekeeper trainings have been prepared and began in June 2007. Trainings will be offered to the following: Maniilaq Counseling Services staff (including village based counselors), Maniilaq Behavioral Health Services Staff (including Maniilaq Recovery Center and Mavsigvik Family Camp), teachers in all 11 schools of the Northwest Arctic Borough School District and one school in the North Slope Borough School District (Pt. Hope), Clinic staff in all 11 villages, medical staff at Maniilaq Health Center, Maniilaq Vocational Rehabilitation staff, Maniilaq Family Services staff, Maniilaq Family Crisis staff, Maniilaq Juvenile Alcohol & Substance Abuse Program (JSAP) staff, Alaska State Troopers, Kotzebue Police Department (KPD), Office of Children's Services (OCS), Department of Juvenile Justice (DJJ), Northwest Alaska Native Association (NANA), Red Dog Mine, Northwest Arctic Borough, Indian Reorganization Act (IRA) for each village, Kikiktagruk Inupiat Corporation (KIC), Friends Church, Assembly of God Church, Church of God, First Baptist Church, Bible Baptist Church, Saint Georges in the Arctic Episcopal Church, and St. Francis Xavier Catholic Church.
    - Project Life staff created a written suicide prevention/intervention protocol for the Village Based Counselors. This protocol will be used as a model to create written protocols for all agencies trained, including each school.

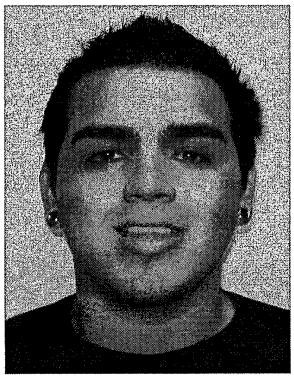
5. Project Life will facilitate the development of community responsibility to wellness. Grass roots community responsibility is the key to sustainability of suicide prevention. Community members will know to respond to a suicide threat, attempt, or death. Community members will intervene appropriately when a person is identified to be at risk for suicide, including referrals to professional helpers.

    - The development of community responsibility will be facilitated by a combination and integration of the activities mentioned above. Some of these have started and will be ongoing throughout the life of the program and some of these will start in the next year of the program.
    - The media campaign has begun, and will continue.
    - Initial introductory visits to each village by Project Life Staff have been completed. Working first with Elders and community leaders, we have built a foundation for future village work.
    - Additional visits to villages with classes and workshops have begun and will continue.
    - Suicide prevention/intervention trainings provided both to agencies, youth, and adults will equip community members with the knowledge and skills needed to respond appropriately to a suicide crisis. All participants in trainings will learn about the warning signs of suicide risk, what to do, what not to do, and how to refer a person at risk for services.

6. Project Life will provide additional support to persons who have attempted suicide by sending non-demanding support letters to these individuals. This intervention has been shown to foster youth help-seeking behavior and reduce future suicide attempts.

    - Project Life staff worked in collaboration with Maniilaq Counseling Services to develop a protocol for introducing the letter writing campaign to individuals who attempted suicide and obtaining their written consent to receive letters (consent from a legal guardian if target person is a minor).
    - Project Life staff developed an Access database for the contact information of participants.
    - Project Life staff developed a letter-sending schedule as follows: first letter: the week following pick up of consent form from Counseling Services; second letter two weeks after the first letter; third letter four weeks after the second letter; fourth letter two months after third letter; then, every two months a letter will be sent. Also, letters will be sent on birthdays and Christmas.
    - Project Life staff have developed text for letters.
    - Letter sending will began in August 2007.

PREPARED STATEMENT OF EMILIO RIOS, MEMBER, THREE AFFILIATED TRIBES



My name is Emilio Rios, and I am an enrolled member of the Three Affiliated Tribes, the Mandan, Hidatsa, and Arikara Nation – of which I am predominantly Arikara. I am also a proud Mexican American. I am very proud of my Indian name – Spirit Wolf, which was given to me by my great-grandmother Arvella White. My name has special significance to me and my family because my Grandmother prayed, and in her vision she saw a wolf, so she selected that name for me. The community from which I am from is New Town, North Dakota – located on the Fort Berthold Indian Reservation in north-central North Dakota with a population of approximately 3,000 tribal and non-enrolled individuals. I have lived in New Town for over 3 years now. Before I moved back to New Town, I was raised in San Diego, California with both of my parents and my younger brother and older sister. My Mom is an enrolled member of the Three Affiliated Tribes originally from New Town, and my Dad is a former gang member from Mexico who was brought up in South Central Los Angeles. Both of my parents were brought up in single parent homes, with parents that were not there for them; also my parents had brothers and sisters, so food was very scarce for them as well. So when I was growing up my parents

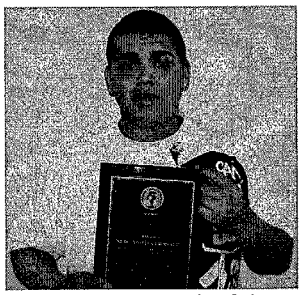
were very strict, but also very loving. In elementary school, I remember I had to walk quite a distance every day to get to the school. When I was in the 2nd grade, I remember my friends and I that walked together to school were always trying to start some kind of trouble. We always wanted to see who the toughest kid out of the pack was, and since I was always the big kid in school, I had to show that I was tough and could hold my own. I got in more than a few fights when I was little, but as I started growing up and understanding the world, my views on the world and what I wanted to do with my life began to change. My Mom and Dad got a divorce when I was in the 4th grade, and that had a huge impact on my life because I always thought my parents were perfect for each other; so when that happened, my brother and I went to live with my Dad, and my sister went to live with my Mom. As a result of this, we moved out of San Diego, CA and into San Marcos, CA with my uncle and auntie and their five children. We lived in a fairly small 4-bedroom home and there were 10 of us - my uncle, auntie, their five kids, and the three of us. When I was going to school in San Marcos every day I had to run home or walk with friends because I would get chased and harassed almost every day from school. Because of all of this, I started hanging out with my Dads homies – or gang associates. My Dad had a lot of homies that were part of a gang in the area, so I had a lot of back-up because my Dad was well known in our town.

I hung out with the homies or the gangsters until I went to high school, then I started to realize that I was messing up my life. I started getting targeted at school, marked by the cops, and by the other local gangs in the area. I didn't like that at all, because it came to a point where I couldn't even walk to the store without getting chased or harassed. I also started getting into drugs when I was hanging out with the gangsters, and I didn't like that or want to do it, but it is a huge part of the gang culture. When I eventually got to high school, the football coach saw me one day and told me to go out for the team, so I did, and the only reason why I joined was to get bigger and stronger for my gang life, but I didn't know how much fun football really was. I started seriously loving the sport! I played football for three years in California, then I was kicked out of my school because I had gotten into a fight with another gang member at my school because the guy had spit on me because he thought I was still residing with the gang I used to hang out with. We both were kicked out of school, and at that point I truly thought my life was over. I didn't care about anything anymore because I got kicked out of my school. So I started hanging out with the homies again, and living recklessly until one day my best homie was killed in our neighborhood, he was stabbed 32 times! When I heard that, I began going crazy and my parents saw that. So my Mom bought me a one-way Greyhound ticket to North Dakota. At

first I didn't like the idea at all – actually I hated it! I hadn't been back in North Dakota since I was a baby, and I really didn't know what to expect. But then I thought about what my Mom was telling me, that I could go to college and receive education assistance from our Tribe, so I made the decision to move to North Dakota and start a new life, and make new friends. I moved to New Town and in with three of my uncles in a trailer where I had to sleep on the floor until one of my uncles eventually moved out. The problem was, my uncles had no priorities except paying the bills. So they had people coming in and out of my house late at night, people smoking and doing drugs, and drinking, so it was very hard for me to go to school and live a regular life in New Town. I dropped out of school half-way through the second semester of my junior year. Because I was no longer in school, I had to make some money for myself because my uncles were not supportive, they could barely support themselves! I got a job washing dishes at our local restaurant until one day my Grandma called me and told me that I had to go to the Alternative School, so I did. The Boys & Girls Club of the Three Affiliated Tribes actually runs, and is located where the Alternative School is held. I began my classes, and I found that with the help of the Boys & Girls Club staff, and the afterschool programs it provides, I began to do pretty well in school, and I actually liked it! Pretty soon I was selected to work for our Boys & Girls Club as a

G.R.E.A.T. Youth Advocate. G.R.E.A.T. is the Gang Resistance Education and Training Program that the Boys & Girls Club administers, so I used the knowledge from my previous life in California to try and help prevent gang activity and violence on our Reservation and within our Boys & Girls Club members throughout Fort Berthold. Working with the Boys & Girls Club staff, I also got back into sports again. I joined wrestling, football, and track and field. In 2008 I placed 7th in the State Class B Wrestling Tournament. This was a huge accomplishment for me because up to that point, I had never won anything in my life, and I owe that to the Boys & Girls Club staff who were the ones that pushed me into sports, encouraged me, and boosted my confidence in myself again. They worked with me so I could attend practice, and still keep my job. Then in March of 2008 I was selected to represent the Boys & Girls Club of the Three Affiliated Tribes at the North Dakota State Youth of the Year Competition – and I won! I was the first member from our Boys & Girls Club to have ever won this prestigious award, and represent the state of North Dakota at the Regional Youth of the Year Competition. I graduated on May 25, 2008 from New Town High School, and have enrolled in and begun classes at Fort Berthold Community College, majoring in Criminal Justice with plans to get my generals, and eventually transfer to the University of North Dakota and get my degree in Criminal Justice and Public

Policy. Honestly, I never in my life thought I could have ever graduated from high school, or even contemplated college. But if it wasn't for the Boys & Girls Club I would have never accomplished the things that I have accomplished, or think of school and my future education the way I do now. I'm truly grateful, and I sincerely appreciate all of the opportunities the Boys & Girls Club have given me. I can truthfully say that the Boys & Girls Club is my home away from home, and I appreciate them more than they can imagine! Thank you for the opportunity to tell my story, and thank you for your support and interest in the Boys & Girls Club of the Three Affiliated Tribes.



Emilio and his Youth of the Year Award

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. BYRON L. DORGAN TO ERIC B. BRODERICK, D.D.S., M.P.H.

Youth Suicide Risk Factors and Garrett Lee Smith Grants: We discussed how risky behaviors associated with suicide are more prevalent in Indian Country and thus American Indians are more at risk for suicide. For example, American Indian youths have a higher prevalence of mental health disorders, like substance abuse and depression.

QUESTION: Are Indian Tribes or institutions more likely to receive the Garrett Lee Smith grants if they address a wide-range of risk factors?

ANSWER: SAMHSA's Request for Applications (RFA) for the *Garrett Lee Smith Youth Suicide Prevention and Early Intervention* grant program states that applicants should "provide early intervention and assessment services to youth who are at risk for mental or emotional disorders, substance abuse disorders, and co-occurring mental and substance abuse disorders that may lead to suicide or a suicide attempt, and that are integrated with school systems, educational institutions, juvenile justice systems, substance abuse programs, mental health programs, foster care systems and other child and youth support organizations."

SAMHSA has been actively working through a federal interagency collaborative effort, "Tribal Justice, Safety and Wellness Government-to-Government Consultation, Training and Technical Assistance" sessions to provide technical assistance in our application process. SAMHSA attributes the increase of tribal funding to these efforts. Tribes are increasing their capacity to compete for SAMHSA's discretionary competitive grants. Within the SAMHSA suicide prevention portfolio, Tribes have successfully been awarded more *Garrett Lee Smith* grants in FY 2008 than prior years. Additionally, the *Circles of Care* grant program provided Tribes significant capacity building so that they could pursue *Systems of Care* grants.

Garrett Lee Smith (*GLS*) Memorial grants address suicide prevention. The 12 Tribes and or tribal organizations receiving *GLS* grants include: Gila River Indian Community; Omaha Nation; Mescalero Apache Tribe; Rosebud Sioux Tribe; The Confederated Salish and Kootenai Tribes; Inter-Tribal Council of Nevada; Crow Creek Sioux Tribe; Oglala Sioux Tribe; Candeska Cikana Community College/Spirit Lake Nation; Sault Ste Marie Tribe of Chippewa Indians; Kawerak, Inc.; and Native American Rehabilitation Association.

The *Circles of Care (COC)* grant was developed solely for American Indian and Alaska Native (AI/AN) communities to design and assess culturally appropriate

mental health service models for AI/AN children with serious emotional/behavioral disturbances and their families. In the last cohort of the *COC* grant, 8 Tribes and or tribal organizations were funded including: the American Indian Center of Chicago; Crow Creek Sioux Tribe; Pueblo of San Felipe; Karuk Tribe; Standing Rock Sioux Tribe; Nebraska Urban Indian Center; Mashantucket Pequot Tribal Nation; and American Indian Health and Family Services of Detroit, MI.

Risk Factors Related to Violent Crimes: Your testimony acknowledges that alcohol and substance abuse are major contributing factors to suicide. Drugs and alcohol also contribute to approximately 90% of violent crimes in Indian Country. You also mentioned the need for an interagency collaborative effort to combat these concerns.

Last year, I introduced the Tribal Law and Order Act. In that bill, I proposed a reauthorization of the Indian Alcohol and Substance Abuse program. The reauthorization would remove the Bureau of Indian Affairs' (BIA) administrative authority over the program and vest it in your office. The program proposes a collaborative effort that would require your office to coordinate with the BIA, the Indian Health Service (IHS), and the Department of Justice.

QUESTION: Can you provide the Committee with your views on that program, and also discuss what tools or other resources that your office would need to help the program succeed?

RESPONSE: The Administration has not taken a position on the legislation at this time. However, as was explained in the testimony, SAMHSA works in tandem with both the Indian Health Service and the Bureau of Indian Affairs to ensure sufficient and effective substance abuse and mental health services for American Indians and Alaskan Natives.

Here is a short list of programs that we currently have that would benefit Indian country and which are available to American Indian and Alaskan Native tribes and tribal organizations.

Screening, Brief Intervention, Referral and Treatment (SBIRT) was initiated in the Center for Substance Abuse Treatment in FY 2003. American Indian and Alaskan Native tribes and tribal organizations are eligible to apply for these grants. The purpose of the program is to integrate screening, brief intervention, referral, and treatment services within general medical and primary care settings. Substance abuse is one of our Nation's most significant public health challenges. The SBIRT approach intervenes early in the disease process before individuals become dependent and/or addicted, and motivate the addicted to pursue a referral to treatment. This is a powerful tool that can not only prevent the human misery

caused by substance abuse but also save millions in health care and treatment costs.

Treatment Drug Courts are designed to combine the sanctioning power of courts with effective treatment services to break the cycle of child abuse/neglect or criminal behavior, alcohol and/or drug use, and incarceration or other penalties. Treatment Drug Courts are being created at a high rate, creating a challenge to support sufficient substance abuse treatment options for people referred by the court.

Other Criminal Justice Activities include grant programs which focus on diversion and reentry for adolescents, teens, and adults with substance use and mental disorders. Criminal Justice program grantees are tasked with providing a coordinated and comprehensive continuum of supervision, programs and services to help members of the targeted population become productive, responsible and law abiding citizens.

All of our criminal justice grants are available to American Indian and Native American tribes or tribal organizations.

Targeted Capacity Expansion (TCE) was initiated in FY 1998 to help communities bridge gaps in treatment services. In general, TCE funding supports grants to units of State and local governments and tribal entities to expand or enhance a community's ability to provide rapid, strategic, comprehensive, integrated and creative, community-based responses to a specific, well documented substance abuse capacity problem, including technical assistance.

Addiction Technology Transfer Centers (ATTC). The ATTAC network is comprised of one national and 14 geographical dispersed ATTCs covering all States, the District of Columbia, Puerto Rico and the Virgin Islands. All of the Centers are highly responsive to emerging challenges in the field. In FY 2007, three collaborations among three ATTCs and three Area Indian Health Boards (AIHB) were funded. Three special project supplements to the ATTCs to partner with AIHBs to provide training and technical assistance to the Tribes have been awarded. The successful applicants for these projects are:

Pacific Southwest ATTC and California Rural Indian Health Board - Will implement training programs on screening, brief intervention, and referral to treatment for staff of tribal health clinics.

Prairelands ATTC and Aberdeen Area Tribal Chairman's Indian Health Board - Will develop and conduct training and technical assistance initiatives for the Tribes, including certification preparation training programs and replication of existing Native American programs across the region.

Mid-America ATTC and Oklahoma City Area Indian Tribal Health Board - Will develop a culturally appropriate foundational substance use curriculum that can be used in a vareity of venues with different audiences.

Research and Data Collection in Indian Country: We discussed at the hearing the difficulty in collecting data in Indian Country. The complexity of the Indian health care system complicates any type of data surveillance.

QUESTION: What type of research is SAMHSA doing on youth suicide specifically for Indian Country?

ANSWER: The 18 Tribes and tribal organizations who receive *Garrett Lee Smith State/Tribal Youth Suicide Prevention and Early Intervention* grants all utilize some of these funds to conduct a local evaluation of their efforts and also participate in a cross-site evaluation that focuses on whether those trained in youth suicide prevention actually use the skills they are taught, and whether youth identified as at risk for services are actually connected to needed services.

In addition, through an Inter-Agency Agreement with the Centers for Disease Control and Prevention, additional funds are provided to the Native American Rehabilitation Association in Portland, Oregon to evaluate the impact of culturally appropriate suicide prevention strategies emphasizing protective factors.

SAMHSA has also provided additional funds to evaluate the White Mountain Apache Tribe's work intervening with youth who have attempted suicide in Emergency Departments, in collaboration with the Johns Hopkins University Center for American Indian Health.

In addition, an evaluation of the Native Aspirations program is underway and initial results demonstrated enhanced readiness to implement suicide prevention. The Native Aspirations contract was established in 2005 to address youth violence, bullying and suicide in AI/AN communities. SAMHSA with IHS assistance identified high-risk AI/AN communities that were invited to develop programs to address the issues from a local perspective. There are currently 25 communities within separate cohorts with an anticipated 65 communities to be served over the next 5 years.

QUESTION: Does SAMHSA find data collection especially difficult in Indian Country?

ANSWER: The National Survey on Drug Use and Health (NSDUH) is SAMHSA's largest survey, providing estimates on the prevalence and correlates of substance use and mental health for the civilian, non-institutionalized population (aged 12 or older) of the United States. The NSDUH sampling process frequently selects households located on Indian reservations. Procedures

for gaining cooperation from persons within these households are the same as those used for any other areas where access might be restricted, such as college dormitories, military bases or gated communities. Typically, interviewers make contact with key persons within the community, explain the survey and its purposes, and receive whatever permissions are necessary to contact the households that have been selected within the restricted area. An informational package, including a video, is available to send to those key persons for whom the initial contact could not be made in person. In addition to controlled access, data collection on Indian reservations poses challenges typical of rural areas, which can be considered costly due to the distances that interviewers must travel between assigned households and segments.

The procedures employed by NSDUH for gaining access to Indian reservations and other controlled access areas have generally been successful. Once access to the area has been gained, cooperation rates are typically fairly similar to the rates obtained in non-controlled access settings. Overall, about 90 percent of households selected for NSDUH complete the household screening interview. However, we do not retain information in our data files that identifies which households are located on Indian reservations. Furthermore, because we do not collect race data prior to screening households, we are unable to compute household screening response rates for American Indians/Alaska Native households. However, for completed household screeners, we do collect the race and ethnicity of household members. Based on these data, we find that the interview response rates (i.e., the percentage of persons selected that complete the interview), indicate that this group is generally quite cooperative with NSDUH's data collection efforts. In 2008, the NSDUH weighted interview response rate for American Indians/Alaska Natives in rural households was 79.04 percent, compared with 74.45 percent among all persons living in rural areas. In urban areas, the weighted interview response rate for American Indians/Alaska Natives was 81.62 percent, compared with 74.08 percent overall.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. JOHN BARRASSO TO ERIC B. BRODERICK, D.D.S., M.P.H.

A shortage of mental health providers has been identified in prior Committee hearings as a substantial issue in addressing Indian youth suicide.

QUESTION: How is SAMHSA working with both the Indian Health Service and other agencies within the Department of Health and Human Services to address this shortage of mental health providers?

ANSWER: SAMHSA works closely with IHS on suicide prevention issues. Both SAMHSA and IHS participate in the Federal Working Group on Suicide Prevention, and SAMHSA also participates on IHS's Suicide Prevention Committee. Given the shortage of mental health providers in Indian Country, SAMHSA has worked, in collaboration with IHS, to promote awareness of the National Suicide Prevention Lifeline (800-273-TALK). The goal of the Lifeline's

American Indian Initiative is to make Lifeline a useful resource to American Indian communities by building relationships with the tribe and with the Lifeline crisis center serving that tribe. The Lifeline has worked with tribes in Montana, Wyoming, North Dakota, South Dakota and Minnesota.

In addition, the White Mountain Apache Tribe, in collaboration with the Johns Hopkins Center for American Indian Health, has utilized their *Garrett Lee Smith* grant to train tribal members who are not mental health professionals to do suicide prevention work with youth who have attempted suicide either in the Emergency Department or in the home following discharge from the Emergency Department.

SAMHSA has also focused on the suicide prevention training needs of the mental health workforce through the Suicide Prevention Resource Center, which has developed a training model for mental health professionals entitled "Assessing and Managing Suicide Risk-(AMSR)."

SAMHSA is developing the Workforce Development Resource Center as an "aggregator" site of Behavioral Health Workforce Development information – a "first stop" for job seekers, employers, recruiters, trainers, and those considering a career in mental health or substance use prevention and treatment.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. MARIA CANTWELL TO ERIC B. BRODERICK, D.D.S., M.P.H.

It is my understanding the Substance Abuse and Mental Health Services Administration has been working on a tribal suicide prevention handbook for several years. Providing Tribes with culturally appropriate, evidence based guidance for suicide prevention is extremely important to preventing youth suicides in Indian country.

QUESTION: Why has the development of this handbook taken so long, and when can we expect it to be published?

ANSWER: SAMHSA has funded the development of an American Indian/Alaska Native suicide prevention guide in order to provide Tribes with culturally appropriate, evidenced based guidance. Following review of initial drafts, SAMHSA determined that additional feedback from potential users of the guide in Indian Country was needed, as well as a deeper focus on culturally specific issues and approaches. That work has now been completed and SAMHSA expects to publish the document, now entitled *To Live To See the Great Day that Dawns: Preventing Suicide by American Indian and Alaska Native Youth and Young Adults*, in 2009.

QUESTION: While your agencies have had some success with programs such as Native Aspirations, which was developed in my home state, how are your two agencies working together to combat youth suicide and the linked issue of drug

addiction? It is important that your two agencies, along with the Department of Justice, work hand in hand to combat these serious issues.

ANSWER: Substance abuse is an extremely important risk factor for suicide and suicide attempts. SAMHSA recently published *Substance Abuse and Suicide Prevention: Evidence & Implications*. This document stresses substance abuse as a risk factor for suicide and suicide attempts and the importance of continued learning about this connection to help prevent suicidal behavior.

SAMHSA's Center for Substance Abuse Treatment is also developing a Treatment Improvement Protocol (TIP) on suicide prevention for substance abuse counselors and programs.

SAMHSA has also consulted with IHS on its Suicide Prevention and Methamphetamine Prevention initiative. *The Garrett Lee Smith Youth Suicide Prevention and Early Intervention* grants encourage collaboration among youth serving agencies, including mental health, substance abuse, and juvenile justice. SAMHSA and IHS will continue to collaborate on youth suicide prevention initiatives and its linkage to substance abuse. The Federal Working Group on Suicide Prevention, which includes representation from SAMHSA, IHS, the Department of Justice as well as other Federal agencies and Departments, will also review this issue as well.

Research suggests that when developing programs to prevent suicide among AI/AN youth it is more advantageous to promote protective factors (like positive self-image, interpersonal communication skills, positive family dynamics, improved academic performance, and tribal connectedness), than it is to eliminate negative risk factors.

QUESTION: Does this resonate with your experience, and what more should be done by State and national programs to help AI/Native Alaskan communities foster these protective factors among their teens and young adults?

ANSWER: In SAMHSA's Center for Substance Abuse Prevention's experience, protective factors in AI/AN communities (e.g., traditional teachings, talking circles, storytelling, cross-generational panels - elders working with younger generations, smudging and other cultural ceremonies) are of utmost importance when addressing not only suicide prevention, but also substance abuse prevention in general. There is no doubt that the suffering and pain present in the AI/AN culture and associated health problems are directly linked to historical trauma, cultural loss, displacement, and multigenerational substance abuse.

These unique cultural challenges warrant a very aggressive approach of addressing risk factors. Strengthening and promoting protective factors is an immediate step that communities can take until direct behavioral health services or resources are implemented to address and reduce some of the "causes (e.g.,

bullying, prejudice, discrimination)" of suicide. Through targeted outreach and strategic programming, State and national programs can expand their efforts to support AI/AN communities strengthen their youth by eliminating risk factors leading to suicide and other self-destructive behaviors. More needs to be done to address the depression, lack of positive self-worth due to unemployment, as well as lack of education and training in AI/AN communities.

Prevention programs cannot focus solely on teaching AI/AN youth to learn to cope with an intolerable situation. According to their research with First Nations communities in Canada, Chandler and LaLonde, determined that suicide rates are "lower within communities that have succeeded in their efforts to attain self-government, or have a history of pursuing land claims, or in gaining control over education, health, police and fire services, or have marshaled the resources needed to construct cultural facilities within the community."[1]

While this can be understood as increasing and improving cultural continuity as a protective factor against suicide, it also means improving and increasing a community's self-control, self-determination, and resources. While many communities may have the necessary control, without the necessary resources, the risk factors associated with suicide will continue unchecked.

State and National programs can take the lessons learned from sources such as the findings from the CSAP National Cross-Site Evaluation of High Risk Youth Programs[2] and consider the following when developing programs:

- Programs with strong behavioral life skills programming and positive alternative approaches, such as refusal skill-building, anger management, conflict resolution, social skills and academics;
- Using interactive rather than passive programming that focuses on building positive connectedness with peers or supportive adults;
- Continue with CSAP's emphasis on positive programming and programs that include clear links between outcome objectives and program activities;
- Provide at least four or more hours of service per week; and
- Provide programs with more positive program components.

In conclusion, in order to bring healing to Native American communities, it is critical that both promoting protective factors and eliminating negative risk factors are implemented.

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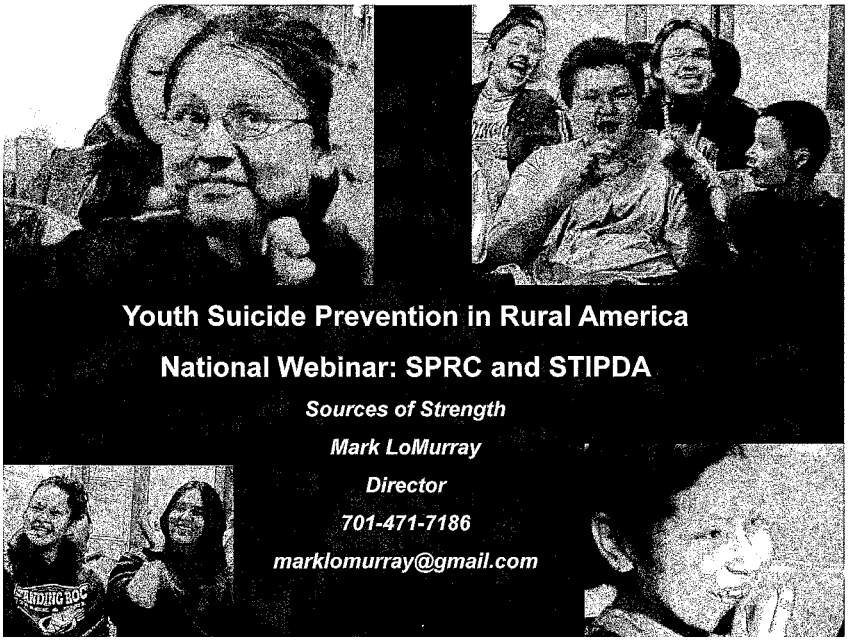
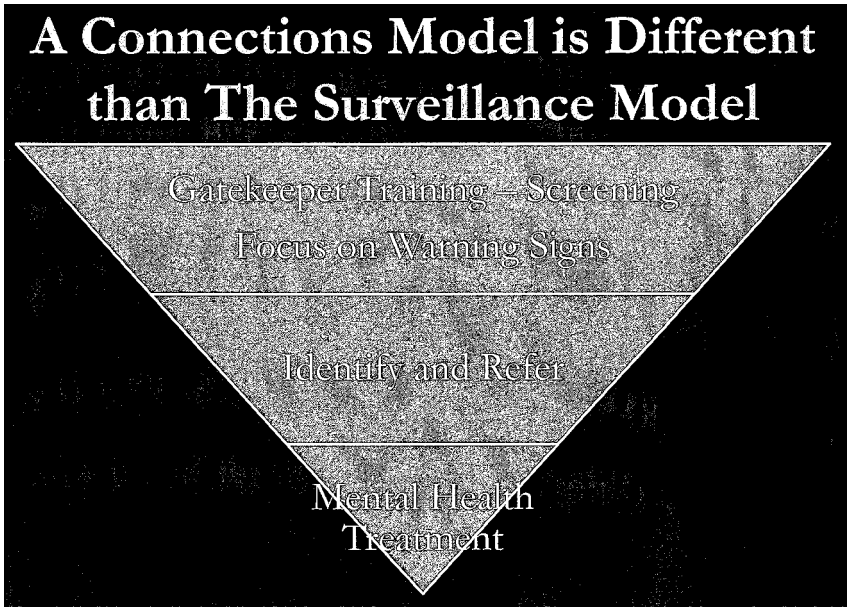
[1] Chandler M.J., & LaLonde, C. (1998). Cultural continuity as a hedge against suicide in Canada's First Nations. *Transcultural Psychiatry, 35,* 191-219.

2 J.Fred Springer, Elizabeth Sale, Jack Hermann, Soledad Sambrano, Rafa Kasim and Mary Nistler, The Journal of Primary Prevention, Vol 25, No2, October 2004



Sources of Strength Description

- A program that trains both adult advisors and diverse peer leaders – with five follow-up action steps that take peer leaders/adult advisor teams three to four months to complete
- Usually school-based, but faith, community, cultural is used.
- The purpose is to reduce codes of silence and promote help seeking by teens to caring adults in their local school and community.
- Started in ND in 1998, used extensively in a statewide campaign from 2000-2004. In 2005 the project received the national APHA Public Health Practice Award – epidemiology section
- Rigorous randomized research is underway in 18 schools in GA, upstate NY, and ND through the University of Rochester, NY and University of South Florida.


A Connections Model is Different than The Surveillance Model
Gatekeeper Training – Screening
Focus on Warning Signs
Identify and Refer
Mental Health Treatment

A Singular Focus on Mental Health Referrals

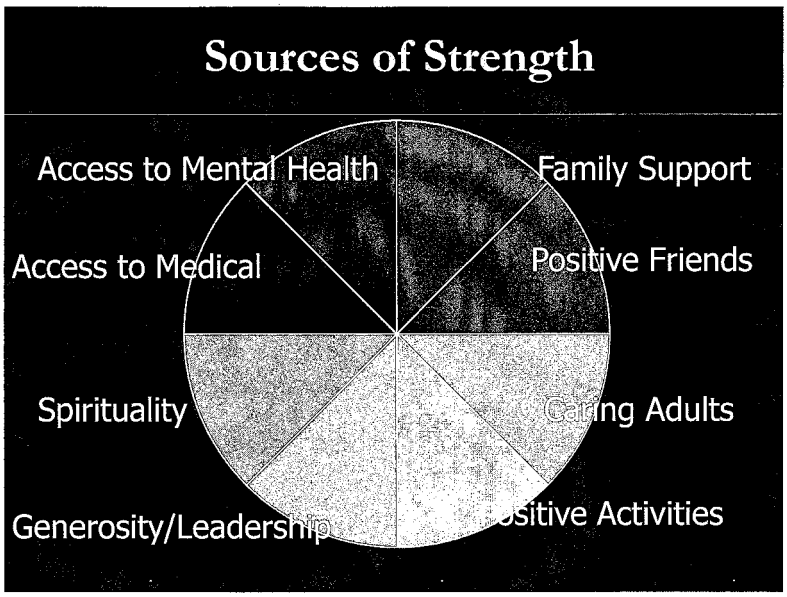
- Leaves rural and tribal communities feeling disempowered
- Rural communities are often mental health shortage regions
- A one way model that requests referrals to medical and mental health services, but generally does not refer back to village-based supports and strengths.

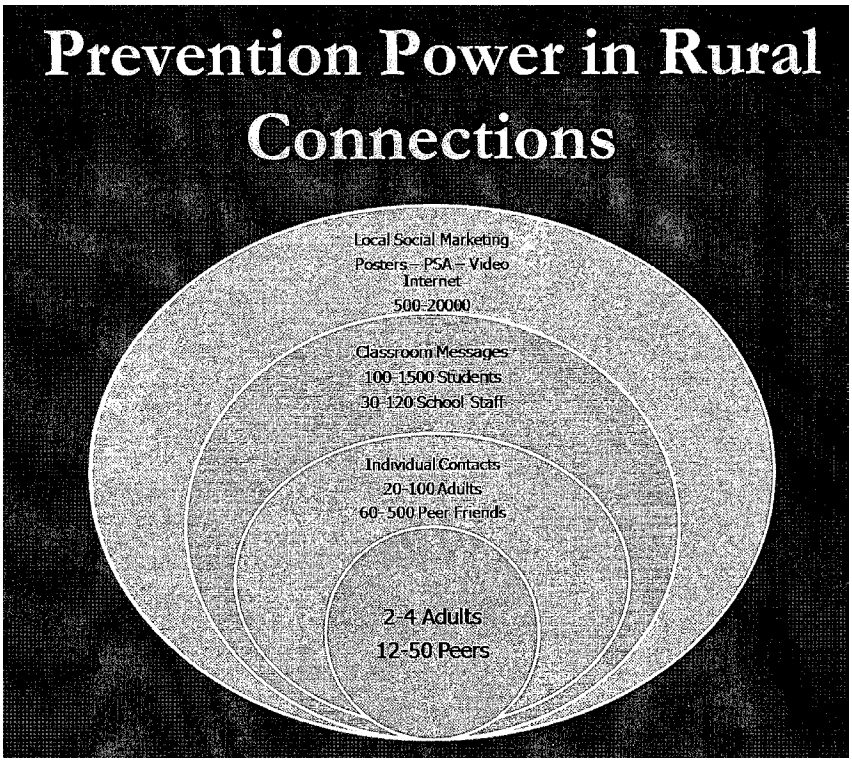
A Connections Model Sources of Strength

- A focus on developing multiple sources of support
- A strength-focused approach
- Bring peers and adults together for prevention power
- Use peer connections to change peer social norms about adult help seeking, strengths
- Spread Hope, Help, Strength messages, not stories of trauma – local faces and voices

Basic Process

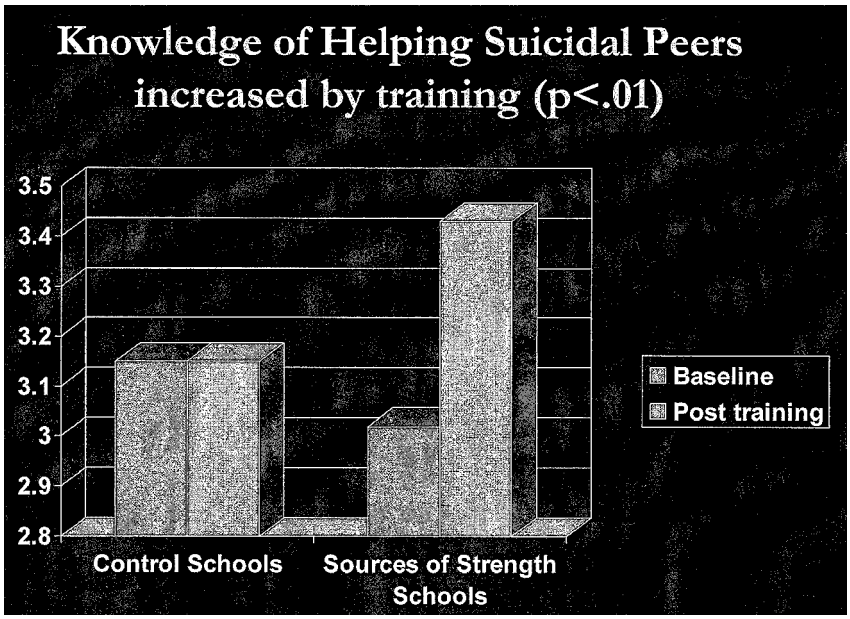
- Awareness Phase -Engage leaders/ administrators
- Review protocol
- Identify and train key adult advisors (2-6 hr)
- Train school or community staff (20 m – 1.5 hr)
- Recruit peer leaders
- Train peer leaders with adult advisors (3-4 hr)
- Peer leaders with adult support begin 5 action steps (3-4 months)

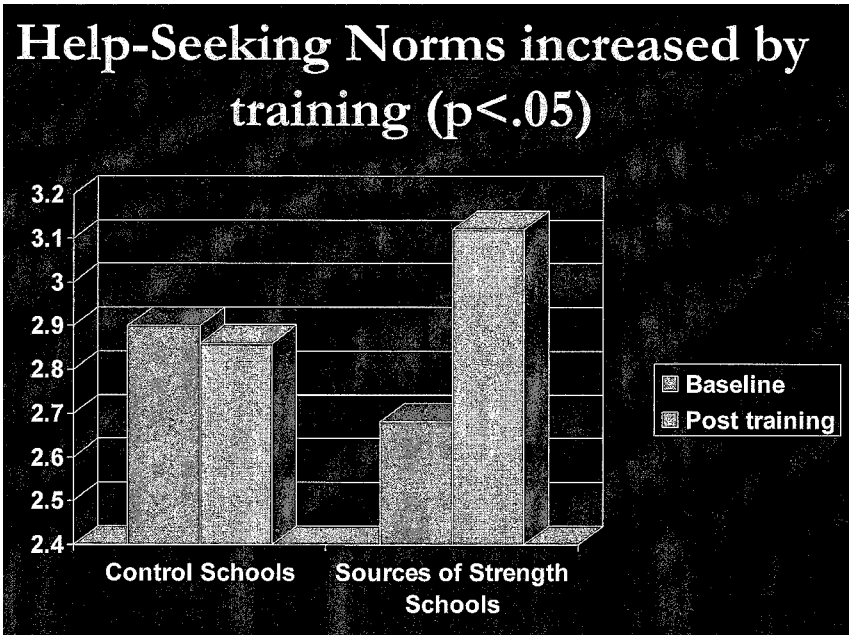

Sources of Strength
Access to Mental Health
Family Support
Access to Medical
Positive Friends
Spirituality
Caring Adults
Generosity/Leadership
Positive Activities



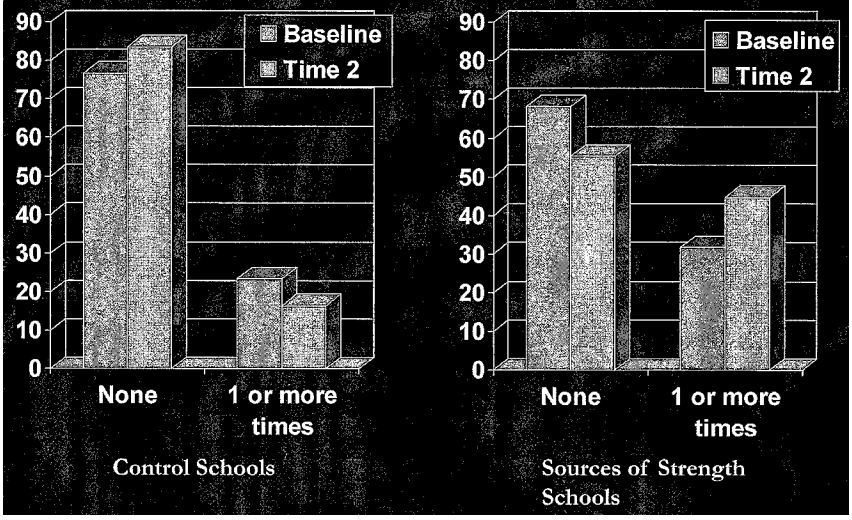
Early Results
Impact of training on 176 Teen Peer Leaders in 6 Schools (GA)

- 6 high schools in Cobb County that already received staff gatekeeper training
- Randomized design – to immediate training or wait-list
- More than 50% of peer leaders aware of suicidal peers
- Positive training effect (at school-level (4 d.f.) on:
  - Help-seeking Norms $p < 0.05$
  - Coping Using Sources of Strength $p < 0.05$
  - Knowledge of helping Suicidal Peers $p < 0.01$
  - **Referral of Suicidal Peers to Adults $p < 0.05$**


Knowledge of Helping Suicidal Peers increased by training (p<.01)
3.5
3.4
3.3
3.2
3.1
3
2.9
2.8
Control Schools
Sources of Strength Schools
Baseline
Post training


Help-Seeking Norms increased by training (p<.05)
3.2
3.1
3
2.9
2.8
2.7
2.6
2.5
2.4
Control Schools
Sources of Strength Schools
Baseline
Post training

Referred a Suicidal Peer to Adults: 2-fold increase by training (p<.05)



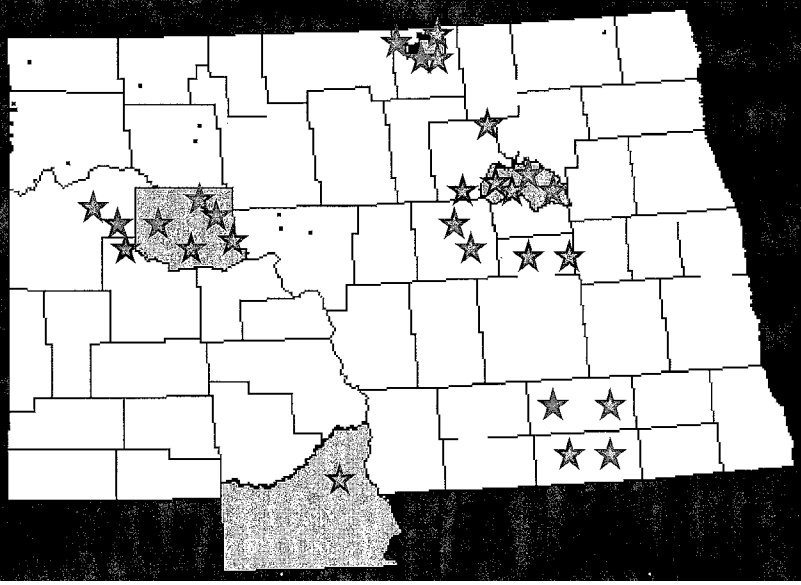
Initial Conclusions for Peer Leader Training (Sources of Strength)

1. In high schools with adult staff training (QPR), peer leaders can be trained and implement 'peer to peer' messaging
2. Training increases Peer Leaders' positive help-seeking attitudes, reduces 'codes of silence'
3. Trained Peer Leaders refer more suicidal peers to adults for help (self-reported), unlike adult training which did not increase referral behaviors in high schools

Promoting Help-seeking Behaviors

- A model that values village-based supports as highly as institutional services.
- Intentional and strategic about using peer and rural connections to change social norms
- Localize – create names, faces, of local supports on a small town, village, housing project level.
- Move from just help seeking around suicide to include strength building behaviors, early emotional distress = caring conversations

Using Data to Focus Resources

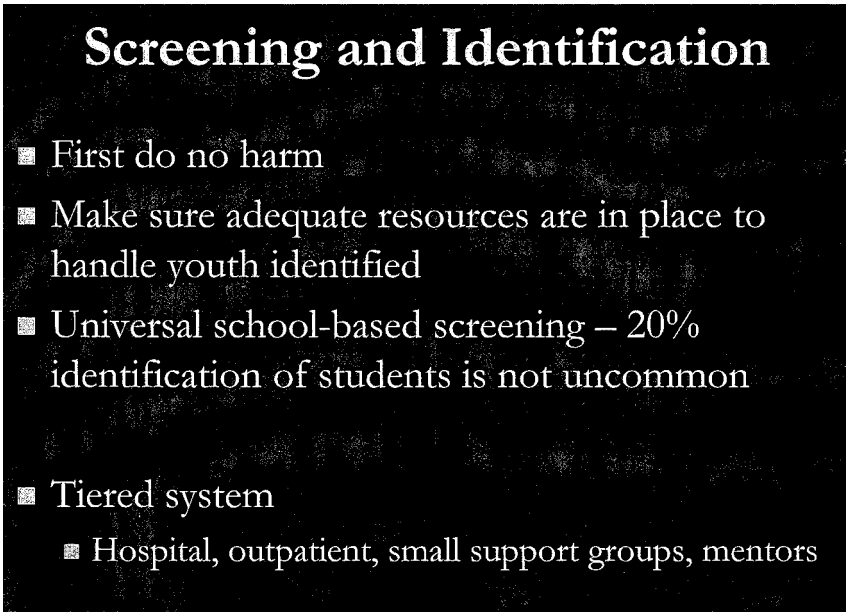


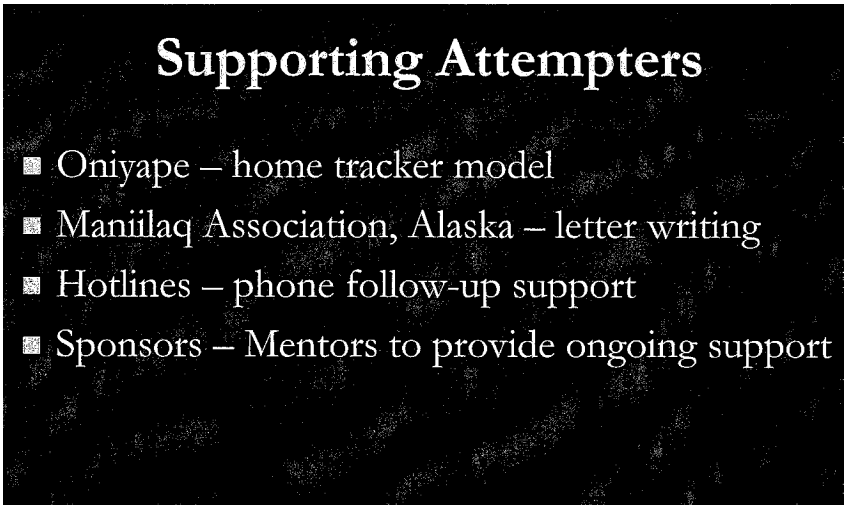
Data and Surveillance

- North Dakota experience of needing to look at a fuller picture
  - raw numbers of suicide fatalities
  - rates of suicide fatalities – gender, age, ethnicity
  - Breakdown into state regions and counties
  - Use ten year averages – recent and long-term trends
  - Compare to national rates and to surrounding states
  - Use YRBS, lack of injury data – ambulance trips
- Surveillance system needed – contagion response

Clinical Care – one example

- Mental Health – Faith-based Partnerships
- Many pastors and spiritual leaders provide a bulk of rural counseling
  - Many lack training
  - Almost all lack support and consultation services
- Be intentional about bringing ministerial-spiritual leaders in regular meetings with mental health providers.
- Encourage cross system referrals


Screening and Identification
First do no harm
Make sure adequate resources are in place to handle youth identified
Universal school-based screening – 20% identification of students is not uncommon
Tiered system
Hospital, outpatient, small support groups, mentors


Supporting Attempters
Oniyape – home tracker model
Maniilaq Association, Alaska – letter writing
Hotlines – phone follow-up support
Sponsors – Mentors to provide ongoing support

2009

Sources of Strength

2009

SOURCES OF STRENGTHS CORE PRINCIPLES

- **Bring together and train both peer leaders and caring adults. One without the other lacks prevention power.**
- **Use peer leaders to break down codes of silence and increase peer help seeking with caring adults.**
- **A core emphasis on strengths that goes beyond a simple focus on suicide risk and warning signs.**
- **Multiple sources of support are encouraged—moving beyond a singular focus on mental health referrals.**
- **Hope, Help, and Strength messages are developed with local voices and faces—saturating local schools and communities with stories of resiliency instead of traumatic stories.**

A Connections Model

The Sources of Strength program operates out of relational connections or a "communication model.". Most suicide prevention efforts are based on a "surveillance model" that focuses on warning signs, and how to intervene and refer a suicidal person to mental health services. Many gatekeeper models begin and end with that

"mental health" intervention in mind.

Sources of Strength compliments and expands on surveillance-based prevention efforts, but focuses heavily on a strength-based approach. A key goal is to increase youth social norms that encourage teens to connect with supportive adults during times of emotional distress. Local peer leaders with adult advisors are trained and supported to use their peer connections to spread positive social norms. Warning signs and mental health referrals are addressed during training, but 3-4 times as much energy is focused on eight sources of strength. Rather than focusing solely on suicide, the program asks how do people stay healthy and make it through tough times –like struggles with substance abuse, trauma, depression, anger, and also suicide. This project encourages a cluster of strengths and supports, that include, but move beyond a singular focus on mental health referrals. The project represents a holistic model that highlights village-based strengths as highly as treatment services.

A core principle of Sources of Strengths is to empower, train, and mentor peer leaders with adult support. Our most hurting young people state clearly that many don't trust adults and only talk to their peer group. Sources of Strength brings diverse peer leaders and links them with caring adults. The Sources of Strength program is intentional about increasing positive social norms—it's strategic in empowering local peers to saturate their schools and communities with messages of Hope, Help, and Strength. It's also purposeful about engaging peer leaders and their peer friends in naming a variety of caring adults that live in their local neighborhood, housing project, or work at their school.

It's all about connectedness—using diverse peers and caring adults and tapping into the power of their relational connectedness. We welcome you to join us in spreading strength throughout your home area.

Mark LoMurray
Director
Sources of Strength

The Sources of Strength Process

Sources of Strength founder Mark LoMurray and peer leaders

A step by step process toward implementing the Sources of Strength Program usually follows this pattern. School-based is most common, but faith. cultural, and community-based teams are also developed.

1. **Awareness–** connect with key leaders and school administrators
2. **Protocol Review** - check with school or community entity on whether several suicide intervention protocol steps are in place.
3. **Adult Advisors—** Identify and train key adults that will mentor peer leaders (2-6 hrs training)
4. **School Staff** - training for school staff or other key adults on basics of Sources of Strength. (20 minutes to 1.5 hrs.)
5. **Peer Leaders—** recruit and provide initial training for peer leaders, this can be middle, high school, or college teams. (3-4 hrs initial training)

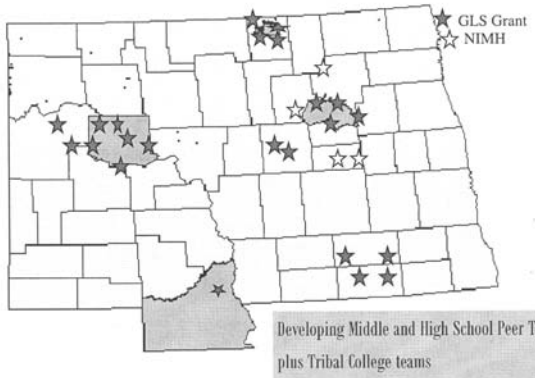
Follow-up Action Steps

1. Peer Leaders contact named caring adults
2. Peer Leaders connect with 5-10 friends—generate other adult names for public poster
3. Peers Create Public Service Announcements for radio or local school announcements
4. Peer to Classroom Presentations
5. Hope, Help, Strength Messages saturate community using posters, create video, internet, texting messages.
6. Celebration/Honoring and peer messages to parents.

2005 National Public Health Practice Award

American Public Health Association—Epidemiological Section

North Dakota Model: Building 22 Local Peer-Adult Teams Saturating Tribal-Rural Areas with Peer to Peer Messages



Developing Middle and High School Peer Teams, plus Tribal College teams

Community-Research Partnership

Peter Wyman, PhD
University of Rochester, NY

The Sources of Strength Program has had the great opportunity to partner in 2007-08 in a rigorous randomized research project in Cobb county, Georgia, funded by the JDS Foundation and SAMHSA. Following that has been a NIMH funded research project for 2008-09 on the Sources of Strength project in rural schools in upstate New York and North Dakota.

The early results from the Cobb County study have shown some encouraging results on Sources of Strength impact on peer leaders.

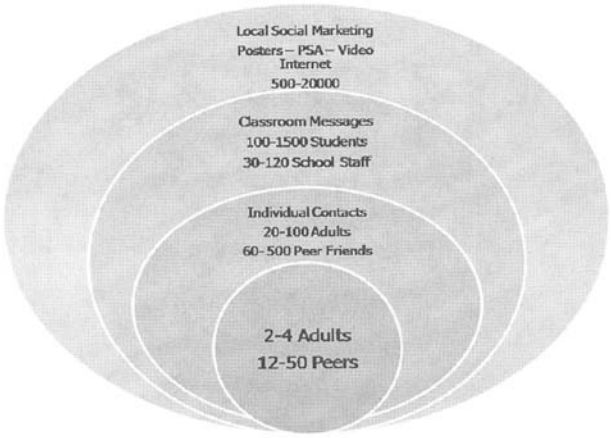
- Coping skills based on Sources of Strength ($p < 0.05$)
- Help seeking from trusted adults ($p < 0.05$)
- Knowledge of helping suicidal peers ($p < 0.01$)

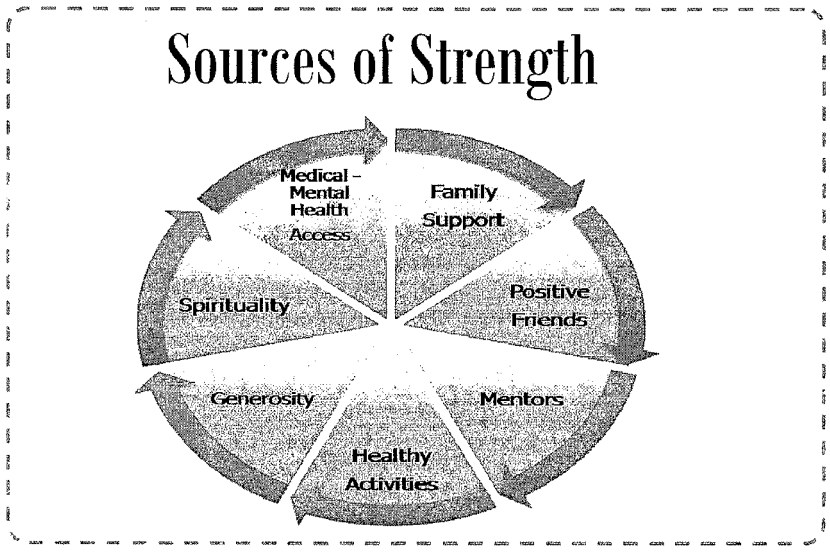
The fact remains that only a very tiny fraction of all suicide prevention programs have participated in rigorous evaluation. At present 18 high schools in Georgia, New York, and North Dakota are participating in rigorous evaluations of Sources of Strength. To learn IF and HOW Sources of Strength affects suicidality in high school students another 24 schools will need to participate in community research evaluation. To determine if Sources of Strength actually reduces suicide rates in young people will require at least 100 high schools.

Most suicide prevention research have focused on treatment programs with few projects rigorously evaluating community and population based suicide prevention efforts. Engaging significant numbers of schools or communities in rigorous evaluation projects like Sources of Strength is a critical step in moving the knowledge of effective suicide prevention forward.

Hendricks Brown, PhD, University of South Florida

Power in Prevention: The Relational Connectedness of Peers





Bring Sources of Strength to your area

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The December 2008 Psychiatric Times article titled *Computer Assisted Psychotherapy* by Dr. Jesse Wright provides an excellent overview on the new computer based therapy tools available today. The article describes *Good Days Ahead* (GDA) that was authored by Dr. Wright. GDA has proven effective for delivery of cognitive therapy to remote locations.

Good Days Ahead is the first computer program to combine the power of interactive multimedia with scientifically tested cognitive therapy methods for fighting depression and anxiety. GDA makes computer-assisted cognitive therapy techniques available to therapists to allow them to treat their patients with the latest cognitive therapy methods. This computer program delivers a significant part of the therapy content in conjunction with the normal therapist sessions. The amount of therapist time can be reduced to 4 hours or less for the total course of treatment that typically requires as much as 20 therapist hours. The GDA computer-assisted therapy program has been found to decrease cost and improves access to cognitive therapy for depression.

The program was created by Dr. Aaron Beck and Dr. Jesse Wright. Dr. Beck is the founding father of the cognitive therapy approach and Dr. Wright is an internationally recognized authority on Computer-assisted Cognitive Behavior Therapy (CCBT) as well as a highly respected physician, author and lecturer on cognitive therapy. He is a Professor and Chief of Adult Clinical Psychiatry at the University of Louisville Medical School.

Dr. Wright's research has proven the efficacy of the program through studies supported by NIH grants. Wright's research program has received grants from NIH and the Department of Health and Human Services. Results of studies have documented excellent patient acceptance of the GDA software and substantial evidence for efficacy. These studies concluded that

> "A multimedia, computer-assisted form of cognitive therapy with reduced therapist contact was as efficacious as standard CBT. Computer-assisted therapy could decrease cost and improve access to cognitive therapy for depression."

In a randomized controlled trial, drug-free patients with major depression had robust responses to computer-assisted CBT, even though the amount of therapist time was reduced to 4 hours or less for the total course of treatment.

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Computer-Assisted Psychotherapy

Human Therapists Still Needed . . .

by Jesse H. Wright, MD, PhD

The prospect of using computers to deliver psychotherapy has been intriguing a number of investigators who have been studying innovative methods of bringing technology into clinical practice. The most dramatic form of computer-assisted therapy (CAT) is virtual reality exposure therapy in which patients are immersed in a virtual environment to help extinguish fears of flying, heights, social situations, or other anxiety-provoking situations. Other commonly used CAT methods are multimedia applications that use video, audio, and interactive exercises to convey therapy concepts and to build coping skills. Handheld devices encourage patients to monitor themselves and to use behavioral methods to manage symptoms. CAT can:

- Reduce cost and improve access to empirically tested psychotherapies.
- Reduce the need for therapists to perform repetitive procedures, such as psychoeducation or rehearsing basic CBT procedures.
- Enhance the therapy experience by providing engaging or unique learning opportunities.[1-3]

Other strengths include giving constructive feedback; promoting use of CBT homework; and recording, analyzing, and reporting data.[4]

The clinician's role

CAT can be defined as psychotherapy that uses a computer program to deliver a significant part of the therapy content or to assist the therapist. Clinician involvement usually includes at least screening, supervision, and support of computer program use and may involve an integrated human-computer team approach to treatment.[4] The amount of therapist involvement in CAT varies considerably in different studies but is substantially less than that in standard therapy. For example, programs that have shown efficacy for depression and panic disorder have reduced the therapist contribution to 4 hours or less for the entire treatment course.[4,5]

Several self-help computer programs that do not use clinician monitoring or involvement are available on the Internet. Although these programs may teach self-help concepts, a recent meta-analysis found that lack of support from a human therapist was associated with far less robust changes in symptoms than was therapy that integrated the work of the clinician and the computer.[6]

Completion rates of program content are usually quite low when a clinician is not involved. For example, a study of the use of Mood Gym, an Australian Web site, found that the vast majority of users appeared to be browsers who only viewed a small portion of the available content.[7] In contrast, an Internet-delivered program for posttraumatic stress disorder (PTSD) that was directed and supported by clinicians was completed by 70% of the participants.[8]

Programs and formats

Early in the development of CAT, attempts were made to construct programs that used "natural language," in which the computer would try to engage users with dialogue that was similar to that used in therapeutic communication between patient and clinician in nondirective or supportive psychotherapy.[1,4] However, these programs were unable to duplicate therapeutic interviews accurately or reliably. Thus, contemporary CAT applications use a different approach—they present learning and skill-building exercises that can help patients better understand and manage symptoms.

Virtual reality applications have been found to be effective for a variety of anxiety disorders.[9-12] For example, Rothbaum and coworkers[9-11] studied programs for patients with PTSD, fear of flying, and acrophobia. Difede and associates[12] recently showed that a program that creates a virtual environment of the World Trade Center attacks on September 11, 2001, was very helpful in reducing symptoms of PTSD. In these studies and others, virtual reality allows the therapist to implement graded exposure treatment in the office while simulating an in vivo experience of the anxiety-provoking situation. The clinician controls the pacing and intensity of the exposure therapy and uses CBT to help patients break patterns of avoidance and extinguish their fears.

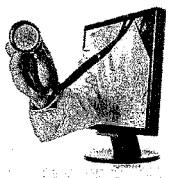
Multimedia programs that have been developed for depression and anxiety are another potentially useful application for CAT. As with virtual reality therapy, these programs typically use a CBT approach, in which patients learn to revise dysfunctional thinking and reverse maladaptive behaviors. Examples of multimedia programs that have been tested for depression include the software Good Days Ahead: The Multimedia Program for Cognitive Therapy and Beating the Blues.[4,13,14]

In a study of Good Days Ahead in drug-free patients with major depression, there were no differences in symptom relief in patients treated with computer-assisted CBT and in those treated with standard CBT, even though therapist contact time was reduced by almost half.[4] The computer program appeared to offer advantages over standard CBT in lowering dysfunctional attitudes and enhancing learning of CBT concepts. The Beating the Blues program led to improved outcomes in both depression and anxiety in primary care patients who had the computer training in addition to treatment as usual.[14] Fear Fighter, another multimedia program developed in the United Kingdom, has delivered results similar to those of standard CBT for anxiety disorders despite use of modest amounts of clinician time.[15]

Handheld computers have also been used as treatment adjuncts. Newman and associates[16] have used this type of CAT to treat panic disorder, and Gruber and coworkers[17] have

NEWS BRIEF

Psychiatric Care: Coming to a Computer Near You?



Persons who live in rural areas in this country often lack access to adequate mental health care. Psychiatrists from Michigan State University (MSU) are tackling their state's lack of resources by providing counseling via videoconference for patients with psychiatric disorders who live in remote areas.

To cope with the growing number of psychiatric cases in Michigan's rural areas, particularly among children and adolescents, doctors at MSU's department of psychiatry may "see" up to 10 patients on any given morning via a video connection without ever having to leave their office.

Psychiatrist Paul Quinlan, who regularly holds videoconferences with patients, noted, "We do take a slightly different approach to establishing rapport, but we're finding patients respond well and are very comfortable." To participate, patients visit their county's community mental health center where they are electronically connected with an MSU psychiatrist. The program, which began 3 years ago, is now at capacity and has become one of the most active programs in the Midwest.

Jed Magen, chairperson of MSU's department of psychiatry, said that the center was developed "in response to a shortage in psychiatrists—a problem seen not only in Michigan but nationwide. The problem is especially acute in child psychiatry. This is the only viable solution." ■

used it to provide CBT for social phobia. Both groups demonstrated that a handheld computer can promote self-monitoring and use of standard CBT methods for anxiety disorders, thus reducing the requirements for therapist time. For example, Newman and associates[16] found that a shortened form of computer-assisted CBT for panic disorder (4 sessions with a therapist) was slightly less effective than a full course of CBT (12 sessions), but there were no significant differences between the 2 forms of therapy at follow-up.

Clinical applications

Although currently available, CAT programs have been effective in research studies; they have limitations in clinical practice. CAT programs do not perform full psychiatric assessments, make diagnoses, or develop comprehensive treatment plans; nor do they screen for and manage impulsivity or other potentially dangerous behavior, such as suicidality. And, of course, they cannot display the empathic concern, wisdom, flexibility, and creativity of human therapists. Thus, in clinical applications, CAT programs appear to be best suited as components of an overall treatment strategy that is prescribed and guided by a professional.

CAT is just beginning to take hold in psychiatric practice. Although a vigorous effort is under way to produce and test programs for psychiatric treatment, and the use of computers in society is steadily increasing, most clinicians are either unfamiliar with CAT or have not yet tried to use these programs to augment traditional therapy. The time may be near when clinicians who want to use technology in psychotherapy will have access to useful and effective programs that can enhance learning, make treatment more efficient, and bring a valuable new dimension to the psychotherapeutic process.

Therapists of the future may be able to conduct their daily work with a variety of empirically tested computer tools. These adjuncts could be completed before or after a session, either in waiting rooms or at home, or even in specially designed therapy suites that provide advanced technology (such as virtual reality and fully realized multimedia treatment programs). Further development of portable devices that have better functionality and connectivity, that offer more realistic and engaging programming, and that weave together the human and technological components of treatment could provide a myriad of opportunities for realizing the promise of the computer as a therapeutic "assistant."

Dr Wright is professor and associate chair for academic affairs in the department of psychiatry and behavioral sciences at the University of Louisville School of Medicine. *The author has an agreement to receive a portion of profits from sales of the Good Days Ahead software described in this article.*

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North Dakota Senator Byron Dorgan, Chairman
Wyoming Senator John Barrasso, Ranking Member

We are writing this letter to put a human face to the issues that face our native people, in particular, drug addiction and suicide. Last year, in January, I lost a best friend to a drug overdose. He was only 18. Five weeks ago, a young girl named Austina hung herself in a room of the drug rehab that she had been admitted into. She left behind a baby boy whose life will be forever affected by her actions. A week after Austina took her own life, a 15 year old girl named Catherine overdosed on prescription pills and cocaine. We see these things all the time. This is an unnecessary reality for our native communities.

Many children on the reservations begin their lives the way that we did. We were born into a lifestyle of self-destruction. As children, we witnessed things no child should have to. Among these things were violence, drug addiction, and abuse. Can you imagine being a child having to hold your mom, the person you perceived to be the strongest, in your arms and listen to her cry because she had lost a loved one to conscious or subconscious suicide? The person who purposely or accidentally takes their own life dramatically affects not only their family but also their entire community. Drug addiction and suicide affects families for generations. We see the consequences of their actions in many ways. My niece, Cyiah, a three year old, asks where her dad is. She is too young to understand the situation she is in. Her mother is a crack cocaine addict who has custody of not one of her 4 children. Her father is no longer alive because he chose to take his life before he could know his daughter. What drives a person to such an end? They leave sons, daughters, sisters, brothers, parents, and friends wondering what they did wrong. The nation's suicide rate is three percent, but in Indian country the rate is four times higher. This can be seen not only in statistics but it can also be seen in our everyday life. We could have told you that the rate was higher just by our experience.

People don't wake up one morning and decide that they want to kill themselves. It is an act that is generated over time. Different things push a person to such an end. From our observations suicide begins to become an option for an individual when the family has become dysfunctional and the environment becomes less conducive to the child's healthy development. For instance, when the child is surrounded by drugs, alcohol, violence and pain, he begins to think this way of life is normal. When such a way of life seems to be all there is, there can appear to be no way out. We advocate strongly for the development of programs which foster a belief in one's self, a belief that is beaten down by the culture of drugs and alcohol. We need Congress to address the issue of teacher recruitment that the No Child Left Behind Act fails to. Our youth need teachers who care about them and their development. A more nurturing environment is needed for children in grades K-12 if we wish to bring a change to our Indian Schools. Help us make this happen by funding our Native American educational and social programs. Address the flaws of No Child Left Behind so that Indian children will no longer be neglected. There are programs such as Teach America which dispatch certified teachers to communities that need it. Why aren't more of these people being sent to our reservations?

For teenagers specifically, we need more of a mentor than an authoritative figure. This is made available through organizations such as the Boys and Girls Clubs, but these programs are largely unavailable to the majority of our reservations. They also are exclusive to younger children. Our native teenagers are crying out for support, love, trust, respect and loyalty from someone. Pressure needs to be put on our federal, state and tribal governments to seriously discuss these issues. We will do what we must to put pressure on our governments, but we respectfully ask you to hold hearings specifically on the issues of drug addiction and suicide prevention. Please advocate on the behalf of our native communities. We would be more than willing to personally testify before Congress or any other governmental body in order to tell our point of view on these issues. When the potential leaders of our tribes are being killed by their own hands at the rates that they are, drastic action needs to be taken. With every young native that dies, a vital part of our tribe is lost.

Thank you for listening to our point of view and for working on our native peoples' behalf. We see the effects of your labor in our lives through the programs that make a difference in our communities. The decisions you make affect our lives in a positive way, so we conclude this letter by asking you to feel in your hearts the pain we feel when we see the urgency of our tribe's situation. Only then might it enable you to go the extra mile for our cause. Many of our youth are lost to suicide and drug addiction every year. Please do everything you can to help this situation.

Sincerely,

/s/ Stephanie Hall
/s/ Whitney Osceola

TIM JOHNSON
SOUTH DAKOTA

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April 30, 2008

Mike Leavitt
Secretary
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Leavitt,

I am writing in regards to the ongoing suicide epidemic that continues on Indian reservations in South Dakota, specifically on the Rosebud Sioux Indian Reservation.

In recent months, I have been in contact with the Rosebud Sioux Tribe regarding their increased suicide rate and their efforts to combat this outbreak. My office has been included on discussions with the Substance Abuse and Mental Health Services Administration as well as the Indian Health Service (IHS) and the Center for Disease Control and Prevention. I am encouraged by the response that has been provided by many of these agencies, and am requesting your continued support to seek resolution to this terrible problem not just on the Rosebud Sioux Indian Reservation, but on South Dakota's remaining reservations and throughout Indian Country.

Recently, I received a letter from the IHS which was a response to an inquiry I had sent to them dated November 16, 2007 regarding this very same issue. In that response, the IHS indicated that 30 percent of the mental health provider and mental health/behavioral health technician positions in South Dakota were not filled. I respectfully request that your agency direct any carryover funds, unobligated funds or surplus funds to fill these positions and for the extended behavioral needs of the Rosebud Sioux Tribe and tribes across South Dakota. I implore you to focus whatever resources that you have at your disposal for mental health services that include prevention, intervention and aftercare services that will help relieve this dreadful epidemic that continues to spread throughout South Dakota and across Indian Country.

Thank you for your attention to this vital concern and I look forward to your response.

Sincerely,

Tim Johnson

A College Suicide Prevention Model for American Indian Students

Jennifer J. Muehlenkamp, Ph.D.[1]

Sonia Marrone, M.A.[1]

Jacqueline S. Gray, Ph.D.[2]

Donna Brown, Ph.D.[3]

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Acknowledgements: This model was designed by Jacque Gray, Ph.D., Center for Rural Health at the University of North Dakota, and was developed for the American Indian Campus Suicide Prevention Project, which is a Garrett Lee Smith Campus Suicide Prevention Grant funded by the Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA # 1SM57856-01).

Abstract

College student suicide prevention efforts are important to campus administrators and mental health professionals due to increasing concerns about managing suicidal students. This paper describes the development and preliminary effectiveness of a campus suicide prevention program designed for American Indian (AI) students, who are at higher risk for suicide compared to the general population. Using the medicine wheel as a guiding framework, the current prevention model integrates communication links between AI tribes and prevention program staff, educational and cultural programming, and spiritual ceremonies with the larger campus mental health resources available to students. A discussion of the barriers faced and solutions generated for implementing the program is offered, along with suggestions for disseminating this AI-specific prevention program to other universities.

KEY WORDS: suicide prevention, American Indian youth, college students, Native Americans

Introduction

College students are among those most at risk for suicide and recent reports suggest the prevalence of suicide in this group increased 8% from 2003 to 2004 (CDC, 2007a). Thus, college campuses represent an important point of intervention as well as prevention of suicide for many young adults. Of further concern, are findings that suicide among American Indians (AI) aged 15 to 34 years is 1.9 times higher than the national average (CDC, 2007b). Select data from the National College Health Survey (American College Health Association, 2005) found that approximately 15% of AI students reported seriously contemplating suicide over the past 12 months compared to 9.1% among non-AI students, and 5.7% of AI students reported attempting suicide compared to 1.2% among non-AI students. These findings demonstrate the need for prevention efforts geared toward addressing specific risks among AI college students.

In addition to common risk factors for suicide such as depression and substance use (LeMaster et al., 2004; Olson & Wahab, 2006; Shaughnessy et al., 2004), there are some suicide risk and protective factors specific to AI youth. One factor that has received recent attention is historical trauma, which refers to inter-generational distress resulting from group genocide, torture, or cultural marginalization (Yellow Horse Brave Heart, 2003). Through the process of colonization and subsequent boarding school practices, AI populations have suffered significant historical traumas that resulted in lost connections to cultural traditions and practices (Yellow Horse Brave Heart, 2003). While few empirical studies have specifically examined the role of historical trauma in suicidal behavior, several authors have identified it as an important risk factor specific to AI suicides (Marrone, 2007; Struthers & Lowe, 2003; Yellow Horse Brave Heart, 1998; 2003). A recent study by the Cedar Partnership Project (2008) examined the role of historical trauma upon suicide in Canadian Aboriginal youth. Results showed a significant

relationship between having at least one parent who attended a boarding school and youth suicide ideation and attempts, suggesting intergenerational trauma is an important risk factor.

Similar to the suicide risk associated with historical trauma, research indicates that those who have managed to preserve or reclaim their cultural heritage tend to have better mental health and reduced suicide risk. A study by Chandler & Proulx (2006) examined the degree of cultural continuity and youth suicide risk. Cultural continuity was measured by the degree to which the tribal community preserved cultural ties to the past as well as the level of tribal self-government. Results showed that a high degree of cultural continuity was associated with significantly lower rates of youth suicides when compared to low cultural continuity communities. Enculturation, which is the extent to which one identifies with traditional ethnic culture, has also been found to be negatively associated with suicide ideation and attempts among AI youth (Yoder, Whitbeck, Hoyt, & LaFromboise, 2006). Furthermore, knowledge and practice of Native American spirituality is viewed as an important protective factor among AI youth. A study of Northern Plains tribes found that commitment to cultural spirituality was associated with a lower prevalence of suicide attempts, even after controlling for age, gender, substance abuse, and psychological distress (Garroutte, Goldberg, Beals, Herrell, & Manson, 2003). These studies suggest that spirituality and cultural traditions are unique protective factors for AI youth. Therefore, including cultural knowledge and practices in a manner that strengthens or reconnects AI students to cultural traditions should be a critical component of suicide prevention programs targeting this group.

Unfortunately, there are few culturally specific suicide prevention models available for AI youth. One program that is available for AI adolescents is the Zuni Life Skills Development curriculum (ZLSD; LaFramboise & Howard-Pitney, 1994, 1995). This program integrates

aspects of Zuni culture into material that teaches life skills known to reduce suicide risk factors and build resilience (LaFramboise & Howard-Pitney, 1994). While the ZLSD curriculum has some empirical support for effectiveness within Zuni tribes (LaFromboise & Howard-Pitney, 1995), it is unclear if its effectiveness generalizes to other Native communities. Similar to the ZLSD prevention program, most AI suicide prevention programs have been developed for youth living in reservation communities (Middlebrook, LeMaster, Beals, Novins, & Mason, 2001), and few have been systematically evaluated for effectiveness (May, Serna, Hurt, & DeBruyn, 2005; Middlebrook et al., 2001). Furthermore, there are no known programs developed to address suicide prevention specifically among AI college students.

The purpose of this paper is to describe the development and preliminary effectiveness of a model of suicide prevention for AI college students that can be infused with the larger university system. The current model utilizes a culturally informed circle of care approach that builds upon mainstream suicide prevention strategies by incorporating AI traditional practices, knowledge, and outreach. The prevention model adopts a supportive approach that emphasizes reaching out to potentially vulnerable students in effort to de-escalate risk for suicidal behavior and connecting them to protective aspects of cultural traditions. The focus is on empowering AI students to discover and utilize culturally appropriate resources, along with existing campus services, to meet their needs.

Overview of the Current Model

Consistent with the AI holistic worldview, the current suicide prevention model attempts to integrate connections between a) AI students, campus departments and services, and tribal communities; b) AI culture and spirituality; and c) educational aspects designed to develop skills, strengthen relationships, and build resilience. To accomplish this holistic approach and maintain

cultural sensitivity across various tribes, the current program is grounded within the AI cultural symbol of the Medicine Wheel.

The Medicine Wheel and its underlying meanings are well known among many AI tribes, but the philosophy originated from the Lakota tribe (Dapice, 2006). The Medicine Wheel (see Figure 1) is sectioned into four multi-dimensional sacred parts that are believed to be strongly connected and represents the circle of life (Roberts, Harper, Tuttle-Eagle Bull, & Heideman-Provost, 1998). These four sacred parts represent many relationships that can be expressed in sets of four such as the four sacred colors (red, yellow, black, and white); the four parts of the spiritual and physical world (mental, physical, emotional, and spiritual); four values of the Lakota (respect, generosity, wisdom, and courage); and the four directions (East, West, North, and South). A key principle of the Medicine Wheel is interconnectedness, which emphasizes that all aspects of one's life influence the others (Coyhiss & Simonelli, 2005). Thus, healing in one area can be impacted by healing in another. The Medicine Wheel is used as a conceptual framework to describe the main components of the proposed model and how the program attempts to address many aspects of AI wellness. The four sources of strength identified within the Medicine Wheel as mental, physical, emotional, and spiritual comprise the core content of the current prevention program model (see Figure 1).

Medicine Wheel Sources of Strength Prevention Components

Mental. Suicide risk detection education is the key element of the mental strength addressed in the current model. A primary educational goal is providing gatekeeper training to all students and faculty/staff who serve on an AI support team. Gatekeeper training curriculum includes the Sources of Strength (LoMurray, 2007) and QPR Gatekeeper® (Quinnett, 1995) programs. The Sources of Strength gatekeeper training was designed for use with Northern

Plains Indian youth and focuses upon helping students to build support networks, re-connect with resources that have been helpful in the past, and build new support networks (LoMurray, 2007). The Aberdeen Indian Health Service adapted the original QPR® program for use with AI persons, and it is this program that is used to train lay and professional persons in the warnings signs of suicidal behavior and how to intervene when someone is suicidal. Training in both Sources of Strength and the AI-QPR® are offered annually to program staff and students, and to tribal or university persons when requested. Additionally, educational workshops on topics such as risk factors for suicide, problem-solving, communication skills, and stress management are provided regularly to students to build mental resilience and health.

Physical. American Indian traditions often involve the preparation of a meal because food is seen as an important venue that nourishes physical needs and fosters connections with others. Food is often used as an offering at cultural ceremonies (e.g., pow wows, sweat lodge, pipe ceremonies), and represents an important aspect of the physical part of the Medicine Wheel. Therefore, this aspect of the model is addressed by offering food at suicide prevention program events. In addition, food is used to bring together AI students and the greater university community to foster connections with each other and develop a sense of trust, which is important for AI students to seek help (Marrone, 2007). Building this connection is accomplished by partnering with existing programming provided by American Indian Student Services. One example of such a partnership involves the suicide prevention program staff's participation in "Soup Fridays," which provides free soup to students, staff, and faculty every Friday. This weekly event serves as an opportunity for students to enjoy a free meal as well as interact with the suicide prevention program staff, along with campus staff and faculty in an informal environment. It is through the continuity of this event that alliances are built with AI students so

they feel more comfortable approaching staff or faculty when a personal crisis occurs. In addition, these informal interactions provide a potential point of intervention that might otherwise not occur because it allows staff to observe student functioning.

Emotional. This aspect of the medicine wheel is addressed in several ways in the current model. First, a program counselor with a background in clinical or counseling psychology provides mental health services in a culturally sensitive manner. The program counselor is based at the AI Student Services Center, providing AI students with direct access to mental health services in a setting where they already access other campus services. Furthermore, the faculty and staff at American Indian Student Services are often the first to observe that a student is struggling with academic and/or interpersonal stressors. Having a mental health provider readily accessible to AI students increases the likelihood that faculty and staff can ensure the student's needs are being met. The program counselor also provides educational seminars to assist students with improving overall emotional functioning such as coping with stress and effective problem-solving. However, there are many issues that can arise among AI students that do not necessarily get communicated to program staff. Students are often in a position where they rely on their peers for emotional support when crises occur while at school or in the student's home community. Our program integrates this informal peer support system within the larger prevention model to further address emotional health and is described below.

One of the factors associated with academic persistence among AI students is social support from their family and tribal community (Montgomery, Miville, Winterowd, Jeffries, & Baysden, 2000; Rousie & Longie, 2001). As a result, students are often negatively impacted by traumatic events that occur on their home reservation. In many cases these events may not always come to the attention of campus personnel. Thus, AI students serve as a vital source of

information, as well as, intervention for students who are experiencing distress. In order to create a bridge of communication between students and campus support personnel, the current model includes an AI student support team. This support team is composed of AI students from the campus community and program staff. Potential student members are identified by peers, university staff, or self-nominations and must apply to be a part of the team. Most students on the AI student Support Team are from a variety of the helping professions including psychology, nursing, teaching, and social work. The most important feature is to have representation from all tribes in the surrounding area so that communication with the reservations can be facilitated.

There are several levels of communication required to make this model effective in addressing the emotional needs of AI students, and to be consistent with the AI cultural worldview that all worlds (campus community, tribal communities) are interconnected. An important part of this model includes developing a network of communication links between students, tribal representatives, program staff, and campus services such as the Counseling Center and University Crisis Team. The connection between university-based and tribal persons provides a line of two-way communication about traumatic events occurring at home that may impact students who are often several hundred miles away from their reservation communities. As a result of the communication links, students on the AI Support Team, as well as program staff, can be alerted to follow up with other students potentially impacted by a home event, ensuring their needs for support and coping are being met. Additionally, the reservation-university program link helps administrators and faculty become aware any ripple effects that may impact the campus, as well as, any AI students who may be affected, permitting early intervention. There are also situations requiring assistance in negotiating absences from classes

or exams to attend funerals or other spiritual and cultural ceremonies that both the AI Support Team students and staff facilitate.

Spiritual. Although there are some universal cultural practices across most AI nations, there is great diversity among tribes with respect to spiritual values and traditions making it difficult to generalize cultural programming across AI groups (Whitbeck, 2006). However, an omnipresent belief among many AI tribes is that traditional knowledge and practices have a strong healing influence, significantly impacting one's well-being and reducing suicide risk (Broome & Broome, 2007; Garroutte et al., 2003; Yoder et al., 2006). Therefore, connecting students with traditional cultural practices is an essential component of the current model. Offering access to spiritual ceremonies enables students to become knowledgeable about traditional AI culture, strengthening suicide resilience. For students already knowledgeable, they can stay connected to traditional practices while pursuing their education from afar.

In order to address the spiritual needs of AI students on campus, a Spiritual Advisory Committee was formed to coordinate all spiritual ceremonies. If a student or staff member expresses a need for a particular ceremony, it is facilitated and provided through this committee. Due to the importance of this committee, it is composed of students, campus staff, and AI community members who are competent in providing spiritual and cultural ceremonies representative of various Northern Plains tribes. Given the considerable variation between tribes with respect to cultural and spiritual practices, the spiritual advisory committee attempts to provide access to as many specific tribal ceremonies as possible so that no one tribal practice takes precedence. Spiritual ceremonies include talking circles, sweat lodge ceremonies, cleansing ceremonies, wiping of tears, and a general AI cultural ceremonies presentation. If there are ceremonies requested that the Spiritual Advisory Committee cannot provide, they work with the

student to identify someone who can perform the ceremony and assist with the arrangement of those services. Thus, the current model provides direct access to AI spiritual and cultural healing venues or persons that can be integrated into the students' university life. Having a connection to traditional spiritual practices on campus helps to prevent student attrition when faced with life stressors or crises, and further promotes the integration of AI cultural supports with the support services offered by the larger university.

Preliminary Data on Effectiveness and Program Utilization

To date, approximately 90 AI students (24.5% of total AI student enrollment; N = 368) have utilized at least one aspect of the AI suicide prevention program. Of those having contact with the program, 4 were directly referred for crisis services, 36 attended program workshops or trainings, around 35 have request/utilized ceremonial venues, and a number have had informal contact with program staff for support services, psychoeducation, or relationship building.

To aid in evaluating the potential effectiveness of different program workshops, pre- and post-data is collected. A 7-true/false item suicide knowledge scale was used to evaluate the immediate outcome of gatekeeper trainings and workshops focusing on educating students about suicide. The suicide knowledge scale items were pulled from existing questionnaires that had demonstrated reliable change as a consequence of participation in a training curriculum (Spirito et al., 1988; Shaffer et al., 1991). Total knowledge scores were calculated by summing response values, with higher scores (maximum score = 14) indicating greater knowledge. Preliminary analyses, collected from 22 AI students who participated in gatekeeper trainings, indicated a high baseline suicide knowledge ($M = 12.56$, $SD = 0.99$). Results from the post-test measure ($M = 13.30$, $SD = 0.93$) show a significant, albeit small, improvement in knowledge, $F(1, 22) = 12.32$, $p < .01$, partial $\eta^2 = .359$. Subjective reports from participants indicate that for 45.7%, the

material presented was at least somewhat new to them; 72.5% stated they would definitely use the information; and 86.3% reported being very satisfied with the training. Recognizing that behavioral markers would provide the best data regarding effectiveness, we can report that at least two students who have used the AI program for crisis intervention were referred by students who attended one of our trainings.

Educational seminars such as stress management, problem-solving skills, and substance abuse awareness and prevention training were also provided. The primary content used in these workshops was adapted from LaFramboise's (1996) curriculum (e.g., Emotions and Stress; Problem Solving; Developing Coping Strategies; Recognizing Self-Destructive Behavior), for college students by using age-appropriate examples and language, as well as integrating Northern Plains cultural pieces. A 5-true/false item pre- and post-measure of workshop content comprised the evaluation of the programming. Total scale scores were calculated by summing responses (maximum score = 10), with higher scores indicating greater content/skills knowledge. Preliminary data show that the workshops have had an impact upon student learning. Pre- (M = 8.75, SD = .71) and post-measures (M = 9.5, SD = .54) of problem-solving knowledge showed significant improvements, F (1, 7) = 5.73, p <.05, partial η^2 = .432. Increases in communication skills knowledge were suggested, F (1, 3) = 3.01, p = .182, but hard to detect due to the extremely small sample size (power = .231). Similar to the gatekeeper trainings, students (n = 35) reported high levels of satisfaction with the workshops (88.6% reported being satisfied to very satisfied). Seventy-five percent of students reported they would use the information learned and 54.3% indicated the material presented was somewhat new, and 22.9% reported the information was new to them.

Barriers to Implementation and Potential Solutions

The current suicide prevention model represents a dedicated attempt to integrate various Northern Plains cultures into a meaningful approach to suicide prevention that both builds resilience and offers support to this population of college students. However, there are potential programmatic barriers to overcome. We highlight the predominant barriers encountered and identify solutions to address them.

Lack of empirically supported prevention resources for AI cultures & college students.

Designing workshops and skills trainings that are culturally relevant across tribes is important to maintaining student connection to the program and building resilience. However, there are few AI specific suicide prevention resources available. Of those available, all have been designed for use with young adolescents. The solutions we arrived at were to utilize gatekeeper programs that have been previously used with AI youth (QPR® Quinnett, 1995; Sources of Strength LoMurray, 2007) as the primary trainings we offer. Additionally, when designing more general workshops (e.g., problem-solving, stress management) we adapted materials from AI adolescent-based prevention programs (LaFromboise, 1996) by modifying the examples and language to be college-age appropriate. To assist with integrating cultural variations across AI tribes in our programming, we have looked to unifying themes, such as the Medicine Wheel, to further inform content and activities. Within the workshops, we facilitate sharing of the unique modifications persons from differing tribes may make to the content discussed to make it culturally meaningful to them. As a result of our solutions, students have reported high degrees of satisfaction with the programming, and a few have used their training to refer students.

Programming staff familiar with AI culture and customs.

Having knowledgeable program staff enhances the cultural salience of the programming, and provides personnel who can lead healing ceremonies and other tribal customs specific to a

tribe ensuring inclusiveness for our AI students. Recognizing that some campuses will not have access to such personnel, one solution we incorporated into the program was having an AI student support team that is integrated with the larger program staff team. The outcome has been that each tribe is represented within our program and these students can provide a "check" on the cultural salience of program offerings. Another potential solution is to identify campus or community personnel who are affiliated with any AI campus programs, or tribes, and engaged these persons. Another solution would be to locate an AI cultural consultant who could assist with program design and ensure both content and activities are culturally sensitive and relevant. Seeking guidance from networks such as the Society for Indian Psychologists would be another way to utilize existing AI-specific resources to inform program content and activities.

Limited cultural knowledge among administrators and key stake holders.

An occasional conflict can arise between administrators and program staff regarding requests for maintaining culturally relevant supplies, facilities, and resources to perform healing ceremonies or other program activities. For example, a request to provide food at a healing ceremony following the death of a key AI person in the student community was denied. This represents a cultural clash because sharing of food during this type of ceremony is synonymous with the custom of communion in Christian rituals and Jewish Passover dinners. Our solution was to provide education about the cultural meaning salient in this request. After providing requested documentation of the cultural importance of this request, we were granted the funds to provide food. However, this may not always be the case. An alternative solution could be to have a "pot-luck" where students who wanted to could bring food as part of the ceremony, or have program staff bring food. Another option would be to seek community or corporate sponsorship of the event. Other potential solutions to address a lack of cultural knowledge among key stake

holders and administrators would be to provide AI cultural education/training seminars for all university persons, as well as informally share information on AI customs. Providing interactive events on campus (e.g., simulated talking circle, AI night at the university cultural center) that demonstrate aspects of AI culture may also help promote greater understanding and knowledge. For example, we had an AI spiritual leader provide a day-long seminar on Native American spirituality and practices that was open to the entire university.

Integrating the AI holistic model within a non-holistic university model to suicide prevention.

Many universities are struggling with ways to provide the best care to suicidal students while managing perceived legal risks, which has led to the adoption of protocols that may be perceived by AI students as punitive. For example, our University utilizes a model (Joffe, 2008) that requires students identified as at risk for suicide to complete three sessions of counseling, placing a hold on their academic record if the sessions are not completed. While one can infer positive intentions with this requirement, it represents more of a disciplinary model than a supportive model. A required treatment protocol may, for AI students, be reminiscent of the boarding school traumas of the past as well as be inconsistent with the holistic or spiritual healing approach respected by AI populations. The solution we have adopted to address this barrier is to provide students access to an AI program counselor. This counselor interacts with AI students on a regular basis and for those who may be at risk, provides initial crisis intervention counseling, facilitating access to further care if indicated. As part of her/his interactions, the AI program counselor informs students about mental health care options on campus, in the community, or on the reservation and assists the student in seeking those services. The outcome of this approach has been positive, with AI student informally reporting they prefer interacting with our program counselor because "trust has been formed" and because s/he provides positive

choices for services rather than mandating a particular approach. While our proposed solution does not change the institutional policy, it provides AI students with another alternative that may be more culturally appropriate. Another solution may include presenting alternative models of suicide prevention/intervention that are more compatible with AI holistic views to the university suicide prevention coordinators for consideration.

Facilitating coordinated care across university health services.

Due to the breadth of the student services offered on campus, integrated care can pose a significant barrier. An example we faced, was that the existing university crisis team administrators initially resisted integration of program staff because they perceived our AI crisis team model to be infringing on their "turf." To resolve this barrier, we spent time with the university crisis team administrators clarifying our model, discussing our focus, and sharing ideas about how the two programs are complimentary and not mutually exclusive. The outcome was that the AI suicide prevention director and program counselor were both added to the university crisis team. Other potential solutions to institutional communication barriers are to increase awareness of the specialized AI suicide prevention program campus-wide, and to maintain frequent communication with the various health services on campus. Some universities may consider forming a student health service committee where the key administrators or directors meet bi-monthly to discuss student care and health promotion/suicide prevention initiatives so that all stay informed and work together. Another possible solution is to have at least one staff person from the various health services as part of the AI prevention program team, or to invite the administrators of the different campus health services to the trainings, workshops, and quarterly program meetings. In general, to be effective, the model needs to be viewed by the university community as another resource and not as a separate or competing entity.

Coordinating with key AI tribal persons.

Maintaining communication regarding tribal and university events relevant to AI students is critical to the successful implementation of the prevention model, but can pose a significant barrier. One solution we built into our program was having either a program staff person or AI student on the support team familiar to at least one tribal person for each of the tribes in our state, who then act as communication liaisons between campus and the home reservation. We also maintain and update lists of health services providers at each tribal reservation in the state so we can facilitate access to tribal care for students who request it. The outcome has been positive, in that program staff have been informed by a tribal person of critical events occurring on the reservation that could potentially affect our students. For example, our program coordinator learned of an event in which a student's immediate family was killed in an accident on the reservation. The program coordinator and other staff persons reached out to this student to provide crisis intervention, a healing ceremony, and link the student to resources both on campus and at the home reservation in effort to prevent suicide risk. The student returned to school sooner than anticipated because of the circle of support he received and recovered from the loss without suicidal behavior. For campuses that may not have access to tribal leaders, a potential solution for this barrier would be to organize an AI student team who could act as liaisons with AI students on campus, informing prevention staff of significant events that may serve as critical events for risk escalation. Another potential solution is to reach out to community members who may have tribal ties and would be willing to facilitate connections. Developing networks between universities in the surrounding area, who may have a larger AI student body or tribal connections, is another option.

Attracting students to programming.

The critical programmatic barrier is attracting students to the programming efforts. Our attendance at program events has ranged from zero (0) to 15 persons. As evident in our evaluation data, the students that have attended tend to have high knowledge regarding suicide risk. Thus, a related barrier is reaching less knowledgeable students. One solution we have adopted is to integrate our programming with other AI student programming that exists on our campus. For example, there is an AI Living and Learning residence hall that frequently has activities and programs. We have placed some of our suicide prevention workshops into their regular schedule. The current model also utilizes social events as "Soup Fridays," as a way to promote connections and obtain suggestions for program events from students. The outcome has been that many of the students who attend the programs are those who have had the informal contact with staff, so this process increases attendance. However, we have not found a working solution for reaching students without high suicide knowledge/awareness. One potential solution we intend to try is using peer to peer networking, in which AI student support team members help present content and specifically invite other AI students to an event. Another possibility is to obtain information about AI students who get placed on academic probation (a risk factor for suicide), and reach out to those students, inviting them to attend program events. Encouraging other university staff and faculty to refer students, or advertise program events would be another potential option. Infusing AI prevention activities into existing multi-cultural events on campus may be another way to reach some students not currently being served.

Program evaluation of effectiveness.

Conducting a feasible and useful evaluation of program effectiveness can also present a barrier. The model was designed so that effectiveness could be assessed from three primary sources: interviews with program staff, self-report data from students who have contact with the

program, and demographic records. Conducting interviews with program staff have helped to further define programmatic goals, initiatives, and programming. However, we encountered difficulties implementing pre- and post-measure data collection at workshops due to inconsistencies across those conducting the workshop. Our solution was to create a standard pre-post template, train all program staff on the importance of data collection, and provide reminders. Workshop leaders could also incorporate the assessments into the program content.

To date, the greatest barrier to program evaluation has been obtaining behavioral indicators of effectiveness. For example, we planned to collect demographic information from campus health services to track utilization by AI students. Due to the loss of our contact person at student health services, and university structure, access to such data was cut off. Furthermore, our campus lacks an integrated database of service utilization so if we were able to obtain access, multiple databases would need to be analyzed. While we have not yet found a solution to this obstacle, one potential solution is to facilitate the creation of a university-wide service utilization database. Stressing the benefits such a system would have for the larger university would probably assist with this effort. Another solution is to partner with the administrators responsible for each service so that access to demographic data for tracking purposes is more easily obtained. Establishing a relationship with the director of student health may be another way to increase access to data and resolve this problem.

Program Dissemination

Recognizing that our AI suicide prevention model has been developed for the unique atmosphere of our campus, there remain core elements of the program that could be applied at a wide variety of universities and colleges. The primary mechanisms underlying the current model for suicide prevention are cultural salience, communication, and outreach support. One of the

primary communication pieces is between AI students, tribal leaders, and program staff. As discussed previously, for campuses that do not have access to tribal persons, developing networks with AI persons through professional organizations, community contacts, and surrounding universities is one way to establish the AI cultural infrastructure of this program. Working with AI students on campus, or establishing an AI organization inclusive of faculty, staff, and students is another way to build the important connections and foster communication between prevention staff and the AI students being served. These connections will enhance the communication as well as provide the needed links between student life and program resources for the supportive outreach.

As for direct prevention events, specific workshop content and gatekeeper trainings can be integrated into existing university programming. Infusing AI cultural content into other multicultural programming is one way to apply the current model in a university setting different from ours. Campuses tend to have organizations designed to assist underserved students and offer training or programming specific to building resilience within these groups. Including training on AI culture and strengths is another way in which to disseminate essential cultural elements of the current model within existing programs. Offering programs or designing events that create welcoming environments and provide a mechanism through which AI students can build connections to both their culture and other persons on campus embodies the heart of the current AI suicide prevention program, and can be implemented across a variety of campuses.

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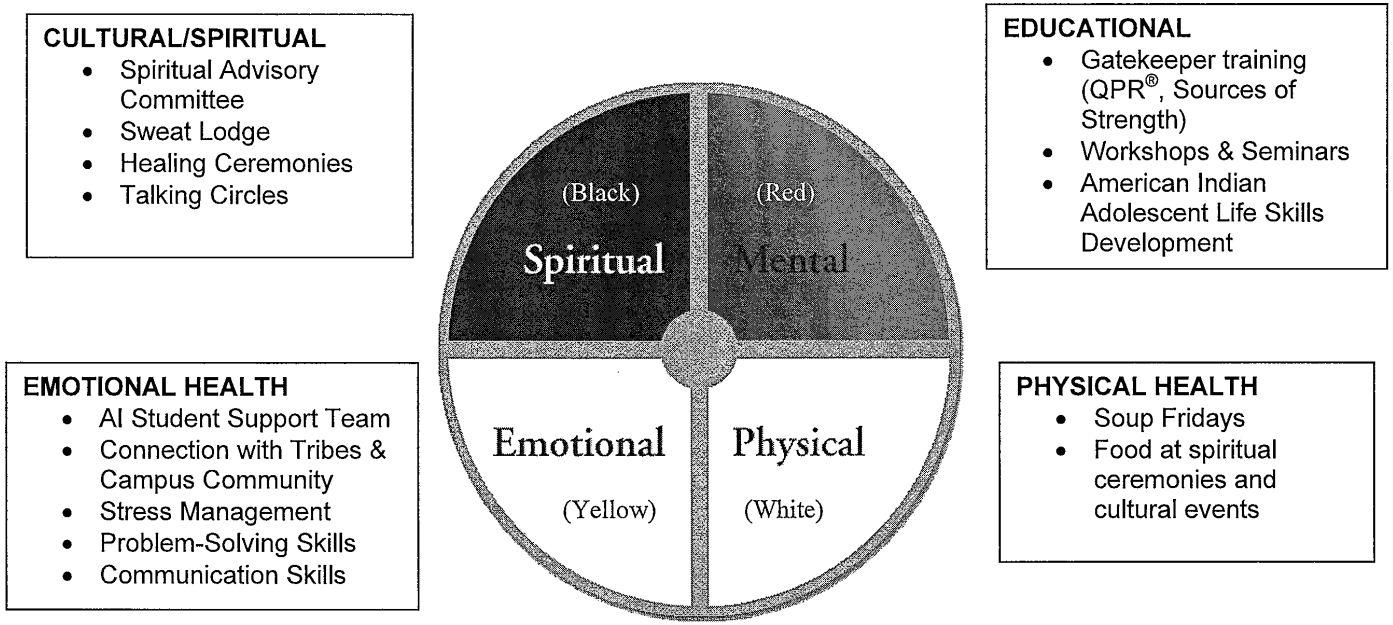
Figure 1. *Program Elements associated with the Medicine Wheel*



ADOLESCENT SUICIDE AT AN INDIAN RESERVATION

Larry H. Dizmang, M.D., Jane Watson, M.S.W., Philip A. May, M.A., John Bopp, M.S.W.

The backgrounds of ten American Indians who committed suicide before the age of twenty-five are compared statistically with a matched control group from the same tribe. The contrast is significant in at least six variables that point to the greater individual and familial disruption experienced by the suicidal youths. Suggestions for treatment and prevention based on the experience of this tribe are offered.

The Shoshone and the Bannocks (grouped linguistically as the Shoshonean) who live in Fort Hall, Idaho, have their origins in at least seven localities, all within the region now called Southeast Idaho and Northern Utah. Both tribes adapted quite similarly to the environment and therefore exhibited no great variations in life styles.

The ecology of the region, at least prior to the greater mobility some bands obtained with the horse, permitted only small groups of people to hunt, gather and camp together. The camps consisted of two to forty people, depending on the season and the availability of small game and gatherable foodstuff. Each camp was composed of bilaterally extended kinship groupings and was extremely fluid; members were free to break off from the group, join another, or go their own ways. Often the reason for departure involved the desire to try a new area of land, to stay with other family members, or a dispute with another camp member. The choice to leave was always individual—that is, there was no ordered or inherited system of leadership that had power over these decisions.[6]

Presented in a similar version at a meeting of the American Psychiatric Association, May 1970. The study was undertaken as intramural research for Center for Studies of Suicide Prevention of NIMH, with which the first three authors were associated.

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Leadership was a matter of proving oneself, of being accepted by the group.[5] Individuals who disagreed with the camp leader simply moved away. Leadership beyond the camp was limited to specific and infrequent communal occasions such as a hunt or religious ceremony.

If a segment of the group departed, it was not always an intact nuclear family. Sometimes, if a man or woman took a new mate and went to live with the spouse's family, children by the former marriage were left with the original group.[2] The responsibility of raising children was often shared with an older sister, an aunt, or a grandmother.[3] It was common practice for children to be raised by several women, which was particularly adaptive in a culture that had to provide emotional and physical protection against loss of the caretaker by early death. It provided the child, from birth, with several "mothers" with whom he had close emotional and kinship ties.

Emotional self-sufficiency at an early age was stressed. Just as a group of mother figures had been culturally evolved to protect the child against early loss, it was also necessary to create cultural defenses to protect the individual from later loss and to insure a high degree of individual autonomy. Any form of dependence on one individual was too risky in a culture that experienced frequent loss of life. The child learned not to verbalize his needs for love, loyalty, and trust. It was expected that he would take for granted that these would be given him as needed, unspoken, and unasked for. He was to endure pain. External aggression, directed towards an outside group of enemies, was the only sanctioned form of emotional expression.[4] Internalization of these values produced adults who were able to withstand frequent loss and separation.

The Shoshonean life style was not finally disrupted until the creation of the reservation in 1869. The policy of the federal government violated Indian concepts of ownership and leadership. To the Shoshonean the Earth was a maternal, life-giving entity from which one could procure sustenance; use never implied ownership. The concept of tribal use was always far stronger than that of individual ownership.[3]

In 1887 it was stipulated that the lands of the reservation were to be parceled out in 40–160 acre plots to each Indian. Whether intentionally or not, the division of land in this manner served to break up the extended family group.[2] Although family groups were separated, child rearing patterns and other traditional social relationships did not change commensurately.

By the early 1800s the Shoshonean were involved in trade with whites. The acquisition by the Indians of metal implements, liquor, and food initiated the beginning of dependence not only on the trade items, but also on the traders. As their source of food and shelter was being decimated, the Shoshonean became reliant upon the white man for their livelihood. This dependence was finally institutionalized by the creation of the reservation system.

Confinement to the reservation meant more than just an end to a nomadic life style. It eroded the economic and traditional structure that had given the male his role and his self-esteem in the culture, and brought on a sense of powerlessness. The male derived his status from his ability to direct the family's moves to areas where game and food-

stuffs were most available. In addition, the male was responsible for hunting small game, a difficult and highly demanding skill. The reservation boundaries limited the area in which to move and, because the game was depleted, food now had to be obtained from the government. The skills of the male were suddenly obsolete and his role within the family group and culture lost all meaning. Thus the matrix for the present social and cultural chaos was created. It is within this cultural matrix that the present conditions of the reservation at Fort Hall have developed.[1] There now exists a situation that exhibits much social and family disorganization. Not only is suicide a significant problem but many other forms of self-destructive behavior are also common, such as alcoholism, accidents, and homicide (often victim-precipitated).

The overall suicide rate for the seven-year period of study at Fort Hall was 98/100,000. This paper will focus on completed suicides on the reservation among individuals below the age of 25. This population was singled out for study because this group accounts for more than one-half of the total suicides! This is in sharp contrast to the non-Indian population in the United States, among whom the suicide rate is lowest among adolescents and rises steadily with age.

SAMPLING

The experimental group in this study consists of all known unequivocal suicides at Fort Hall of Indians under the age of 25, from 1961 through 1968. The suicide sample consists of ten individuals ranging in age from 15 to 24. In addition, there were seven other completed suicides that occurred within this same time period, but because of the unusually high incidence of suicide among the younger age group, only the subjects under the age of 25 were examined in this study. Undoubtedly, there was a significantly larger group of suicides during this period of time than was recorded; since a number of individuals in this age range died violently, many of these deaths may have been either suicidal in intent or victim-precipitated homicide. This study includes only those cases where suicide was clearly and unquestionably the cause of death.

The control group was chosen by stratifying the sample on the basis of the following variables: 1) age; 2) sex; 3) degree of Indian blood (within one-eighth degree)*; and 4) no known suicidal attempt by the control member or anyone within his nuclear family or household prior to the death date of the matched suicide subject.** A control group consisting of four individuals matched by the above variables was selected for each of the ten suicides.

The actual selection process was accomplished by the use of the random-quota method. The Tribal Census of 1960 was obtained and for every control group a random starting point was selected. From this random point selec-

* In one case, it was not possible to select a fourth member for a control group which matched the suicide in degree of blood. A control was selected who was one-fourth degree lower in S-B blood but who matched the suicide in degree of Indian blood.

** If a control member had experienced a suicide or an attempted suicide in his nuclear family or household, or had attempted himself, he was excluded from the control group and a replacement was selected. Deletions occurred five times throughout the selection of controls.

tion of the four members in each control group was made by going down the Tribal Roll (which is arranged alphabetically according to heads of households) and selecting the first four individuals who matched the criteria. Thus the ten suicides were matched against 40 control subjects.

PROCEDURE

A data survey form was designed to collect information on each subject. The final data analysis sheet is a 104-item survey of each subject's background as well as the background of his family. This survey form is divided into five categories: family background, health and clinic record, law and order record, educational background, and personal data.

For each suicide and control in the sample, a survey form was filled out as completely as possible from existing records, including the Indian Health Service Clinic; the Bureau of Indian Affairs police records, social service, employment and education records; and from the local schools attended by the subjects. In addition, one member (J.W.) of the research team lived for a period of fourteen months on the reservation and collected much personal data from interviews with individuals and family members when the data did not exist in the official records.

After initial examination of the data sheets, some of the variables were discarded because of insufficient data. No item was used in the statistical analysis where information was lacking on more than five control subjects. In the final analysis, 35 variables were examined in relationship to their distribution, standard deviation, means, and variation. A t-test (one-tailed) was run on the 35 variables comparing the characteristics of the suicide group with those of the control group. Six items proved to be statistically significant to at least the .025 level.

RESULTS

The first significant variable indicates that 70% of the subjects in the suicide group had more than one significant caretaker before the age of fifteen, as compared to 15% of the control group (significant to the .005 level, $t=2.771$; $df=48$).* In other words, the subjects in the suicide group were frequently cared for by more than one individual in their developing years, while most control group subjects were cared for by one caretaker.

A second finding indicates that 40% of the primary caretakers of the suicidal group had five or more arrests, as compared with 7.5% of the controls (significant to the .005 level, $t=2.747$; $df=48$).

As indicated by a third statistic, 50% of the suicide group experienced two or more losses by desertion or divorce, while 10% of the control group had the same experience. The subjects in the suicide group suffered significantly more loss by desertion and divorce than did the controls (significant to the .005 level, $t=3.438$; $df=48$).

The remaining variables consider the subject directly, rather than his family. Among the suicide subjects, 80% had one or more arrests in the twelve-month period preceding his death, while 27.5% of the controls were arrested one or more times in a similar twelve-month period

* Significant caretaker is defined as anyone who has had prime responsibility for the subject for a span of six months or more in the subject's first fifteen years.

(significance at the .005 level, t=3.324; df=48).

Other variables that also concerned arrest records were tested, and it was found that the total number of arrests did not distinguish the control and the suicide groups. However, there was a significance found in the age of first arrests. By the age of fifteen, 70% of the suicides had been arrested, as compared to 20% of the controls (significance to the .01 level, t=2.583; df=48). Thus, it is *not* the number of arrests that separates the two groups, but the timing of the arrests. The suicidal youths suffered *both* more arrests in the year of their suicide and were arrested at a significantly earlier age.**

The final statistic for discussion concerns Indian Boarding School. Among the suicidal youths, 60% were found to have attended boarding school by or before the ninth grade, as compared to 27.5% of the controls (significance to the .025 level; t=2.088; df=48). In addition, the total percentage of the suicide subjects who attended boarding school was 70%. This was more than twice the percentage of controls (30%).

DISCUSSION

It does not take any detailed or intricate analysis to look at the results and realize that all of the factors that are statistically significant point to a single common denominator. The level of significance of the data only serves to underscore what is clinically obvious when one visits the reservation. The family and social choas that the suicide group experienced was certainly relative, since almost no one on the reservation can escape the reality of his history and the cultural disintegration that has taken place in the last 75 years. There can be little doubt that the individuals who committed suicide experienced far more individual disruption in the early formative years of their lives than did the controls. The internal unrest of the individuals who committed suicide was manifested by the earlier age of first arrests and the larger number of arrests the year prior to suicide. The data concerning the significant caretakers is only a sketchy outline of some of the early loss, desertion, and insecurity these children must have experienced.

There was one interesting phenomenon that seemed to be an additional factor in accounting for the increased number of caretakers of some of the suicidal individuals. The old traditional patterns of child rearing in an extended family still have some influence on present customs. In the early days, mother, grandmother, aunt, and older sister were usually part of the caretaking system for the children, and they lived in the same band. These individuals are still felt to be part of the caretaking system of children but now they often live many miles apart. When mother raises the child for the first couple of years of his life and then shifts the caretaking responsibility to grandmother because of another child, etc., grandmother is a relative stranger to the child. The child may then experience one or more early "losses," even though a particular nuclear family may be relatively intact. Thus, a culturally-evolved mechanism with high adaptive qualities becomes a serious problem in a new context.

There is a need to offer suggestions on how to remedy the situation, and yet

** Arrests for the controls were considered only if they occurred prior to the date of suicide of the youth with whom they were matched.

the suggestions seem painfully obvious. One cannot undo the trauma of history overnight in terms of its present impact upon the individual or the collective lives of a people. A simple change or changes in federal policy will not remedy the situation. Additionally, there are a number of advocates of different and conflicting policies, which only serves to increase the confusion.

It is accurate but insufficient for the Indians to blame many of their problems on the white man at this point. Just as an individual in psychotherapy may have had a "bad mother" on whom he can blame his present trouble, it is only at the point he is able to "work through" the past traumatic experiences that he becomes able to stand on his own and deal with current reality more effectively. Once the individual or cultural pattern has been set it becomes the problem of the individual or cultural group to work through those problems that were forced upon them at a point in their existence where they were powerless to alter the course of events. The Shoshone-Bannock Tribes have begun this task.

Since the initial NIMH consultation in 1967 there have been some important changes on the reservation. It was clear that there was a significant group of individuals who were concerned about suicide as an important part of the overall problem. The need was expressed by the Tribes for help with the suicide problem and, after consultation, a recommendation was made for the various agencies involved, including the Tribes, to develop a medical holding facility on the reservation. The adolescents and young adults of the Tribes, when picked up by the police for intoxicated or disruptive behavior, would be returned to the reservation and treated medically, instead of being put in the white man's jail.

The data presented supports the initial impression that those individuals showing arrest at an early age and those individuals with a large number of arrests the year prior to the suicide were also the ones most likely eventually to commit suicide. The majority of arrests prior to the suicide were for intoxication, glue sniffing, and rowdy, aggressive behavior, and not for serious crimes. It was felt that if these individuals could be treated by medical rather than legal means, there was hope of identifying those in the most "psychological trouble." By having them returned to the reservation, they could be seen by the Public Health Service physician and the social worker immediately, where it would be possible to screen them carefully. In those cases where it seemed warranted, a follow-up plan was employed.

Currently, two years later, there is a medical holding facility on the reservation that is run by the Tribal Business Council and staffed primarily by volunteers from the Tribes, who take turns being on call in order to respond to crises as they occur. It is far too early to make any generalizations, but in the last eighteen months, and since the time this facility was in the active planning stages, there has been only one suicide—an individual over the age of 30 who would not normally have been seen at the holding facility under present circumstances. There have not been, in the last eighteen months, any suicides in the age group for which the holding facility was primarily designed. According to the experience of the previous seven years, two or three suicides below the age of 25 would have been expected during this period of time. Again, we do not want

to draw any conclusions from this observation, as it will take much more time before the effectiveness of this facility can be evaluated. We think the major point of importance is that the Tribes have made significant although often painful efforts to begin to pull themselves together and to begin to deal with the tragedy that they have experienced. They have shown that they do have the capacity to come together as a group to face their difficulties and to work actively towards a solution that does not primarily depend upon the federal or local governments, but rather upon their own people and their own resources. This, to us, is a remarkable show of strength on their part and not only a clear will to live but a will to pick up the pieces and once more become a group with an identity of their own and of which they can be proud.

CONCLUSION

The data presented clearly indicate statistically significant differences between individuals who commit suicide and the control group. The subjects in the suicide group were frequently cared for by more than one individual in their developing years, while control subjects were almost always cared for by a single individual. The primary caretakers of the suicide group had significantly more arrests during the time they were the caretakers of the subjects. The suicide group also experienced many more losses by desertion or divorce than did the control group.

The individuals who committed suicide were arrested more times the year prior to their suicide than were the controls, although the lifetime number of arrests did not distinguish the control and the suicide group. Those who committed suicide were arrested at a significantly earlier age than those in the control group. Many of the completed suicides were sent off to boarding school at a significantly earlier age than were the control group, and they were also sent more frequently to boarding school for some period of their life than were the controls. All of the data point to a chaotic and unstable childhood in those who completed suicide, compared to the controls.

This study only serves to underline what is already clinically known by those individuals who have spent time with any tribe of American Indians whose culturally evolved ways of relating to the world have been significantly disrupted by the white man's intrusion, resulting in cultural and family disorganization. There is no simple solution and it is impossible to undo the reality of the past. Every tribe must work out its own individual solution in order to regain some sense of identity and pride that "I am an Indian" and, in the case of Fort Hall, that "my father was a Bannock" or "my father was a Shoshone."

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An Update on American Indian Suicide in New Mexico, 1980–1987

NANCY WESTLAKE VAN WINKLE and PHILIP A. MAY

This paper updates a previous study of American Indian suicide in New Mexico which covered the years 1957–1979. Rates for completed suicides among the Apache, Navajo, and Pueblo for 1980–1987 are compared to earlier rates, as are selected demographic and situational variables. Major findings suggest that suicide rates are stabilizing or declining for all three groups in the most recent years. For the Apache and Pueblo groups, however, this trend may just be the downswing of cycles that have been identified by this study. Age-adjusted suicide rates for all three groups remain above US rates for 1980–1987, but some of this difference may be attributable to regional variation. Age-specific rates for all three groups remain above US rates for most age groups under 55 years. Apache rates are still the highest, followed by Pueblo and Navajo rates. A comparison of Indian and non-Indian suicide rates in New Mexico indicates higher rates for Indians, particularly in those counties where the Apache and Pueblo tribes reside. Suicide among all three groups continues to be primarily a young male phenomenon.

Key words: American Indians, mortality, New Mexico, suicide

AMERICAN INDIAN SUICIDE is a phenomenon that has received sporadic attention over time, often in response to "suicide epidemics" on individual reservations. A number of articles have reviewed the existing studies (May 1987, 1990; McIntosh and Santos 1981; Peters 1981; Santora and Starkey 1982) and there are now over 160 articles, papers, and reports on the subject of self-destruction among Indians. Most of the above reviews and many individual works highlight the fact that the suicide phenomenon varies among the diverse Indian cultural groups.

Some authors have focused their attention on suicide among the various Indian cultural groups in the Southwest (Everett 1970; Levy and Kunitz 1969, 1971, 1987; Wyman and Thorne 1945). Two of the most comprehensive contemporary studies were conducted by Levy (1965) and Van Winkle and May (1986). Both of these studies used mortality data to explore the comparative picture of suicide among the Apache, Navajo, and Pueblo groups in New Mexico over time. Levy's study covered 1954–1962, and Van Winkle and May covered similar issues for the years 1957–1979. In these studies the authors compared suicide trends as well as demographic and situational variables among all New Mexico Indian groups. Results of these overlapping, longitudinal studies indicated that suicide rates had fluctuated for each group over time, but that rates were increasing for all groups by the early 1970s. Moreover, suicide among the Apache, Navajo, and Pueblo was found to be predominantly a phenomenon of young males who were particularly prone to the use of firearms and hanging, which tend to result in almost certain death.

American Indian suicide is still a topic of interest for researchers and a number of articles have appeared recently (DeBruyn, Hymbaugh, and Valdez 1988; Forbes and Van Der Hyde 1988; LaFromboise and Bigfoot 1988; Manson et al. 1989; Thompson and Walker 1990; Tower 1989). Nevertheless, few recent studies have addressed suicide or suicide attempts among members of the Apache, Navajo, or Rio Grande Pueblo cultural groups (Becker, et al. 1990, Grossman, Milligan and Deyo 1991, Howard-Pitney, et al. 1992). Recently Thompson and Walker (1990) critiqued a number of studies of Indian suicide. Among their points were: 1) that studies tended to focus only on small groups with high rates; 2) that more studies needed to use appropriate comparison groups, such as other tribes; 3) that studies should utilize longer time periods in their analysis; and 4) that studies should utilize larger sets of data. All of these are valid points.

There are few epidemiological or demographic studies that aspire to deal with the issues raised by Thompson and Walker. Most recent articles deal with other topics, such as assessing suicide lethality in school-age youth and suicide prevention programs (Lin 1987, Manson et al. 1989, Neligh 1988). Seldom have researchers returned to reservations or other local areas

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a number of years later to undertake follow-up studies or to examine changes in suicide phenomena (Fox, Manitonabi, and Ward 1984; Levy and Kunitz 1987; May 1987). A longitudinal perspective is vital in understanding a volatile topic such as suicide.

This study addresses the issues raised by Thompson and Walker (1990). It is an extension and update of an original study of the Apache, Navajo, and Pueblo of New Mexico (Van Winkle and May 1986). This paper covers the years 1980–1987. When coupled with the original paper, the time period covered is 31 years of suicide experience for the same state. This article reports on recent suicide rates, compares these rates to US rates, compares the demographic and situational data to those of the original study, and discusses possible reasons for the findings. It focuses on trends in the data, and also briefly addresses the theoretical underpinnings of the study. For an initial review and presentation of the relevant theories, the reader should consult two previous studies (Levy 1965, Van Winkle and May 1986).

Methods

To ensure comparability to earlier works, data for this study were obtained from death certificates registered with the New Mexico Health and Environment Department from 1980–1987. A comparison of these data was made with information obtained from the Office of the Medical Investigator in Albuquerque, New Mexico to strive for the most complete list of suicides. The suicides included in the following analysis were restricted to those Apache, Navajo, and Pueblo Indians who died in New Mexico and who were residents of New Mexico at the time of death.

Population estimates used to calculate rates for 1980–1987 also came from the Indian Health Service in order to be consistent with the original study.[1] These population figures are based on resident populations, rather than enrolled tribal populations, and are calculated from the Census of the United States.

As was discussed in the previous study, suicide rates for New Mexico Indian cultural groups may be slightly inflated due to an undercount of the Indian population by the US Census Bureau. It is believed that the Census undercounts the actual Indian population, but the margin or error for the suicide rates from 1980–1987 reported in this study represent an inflation rate probably no greater than 0.4 to 3.2% (Passel and Berman 1987:177–178). Another factor that may inflate rates slightly is the use of a resident population base while including suicides by New Mexico Indians who may not be residing in their IHS service area. This inflation is offset somewhat by excluding those members of the resident population who commit suicide but die outside of New Mexico, and by the fact that suicide is an underreported phenomenon (Rosenberg et al. 1987:433). Despite these shortcomings, use of this population base is justified because it is the most complete, consistent and detailed estimate of these populations available.

Unlike the earlier time period, tribal affiliation was recorded on most death certificates during 1980–1987. In the few instances when it was not included, tribal affiliation was determined from the information on birthplace, burial place, surname, and place of residence at the time of death.

Results

Rates and Ratios

There are some positive as well as negative findings about the trends in suicide among the Indians of New Mexico during the 1980s. As one can see in Figure 1 and Table 1, suicide rates based on three year averages seem to be staying the same or declining in recent years. Apache rates peaked in 1980 (69 per 100,000) and 1985 (67.6 per 100,000) and declined in 1986 (36.5 per 100,000). There is an exaggerated fluctuation for this group because of the small population base which yields large swings with few actual suicides. Navajo rates fluctuated little during the 1980s, with a range of 14.5 to 18.7 per 100,000. Pueblo rates rose in the early 1980s and have been declining steadily since 1983 with a range of 23.2 to 44.1 per 100,000. If these results are viewed optimistically, one could speculate that the stabilization or decline in suicide rates seen for all three cultural groups by 1986 will continue.

If one looks more closely at Figure 1, a cyclical pattern emerges for suicide rates of both the Apache and Pueblo groups. The Apache rates appear to be rising and falling in five- to six-year cycles, while the Pueblo rates seem to be fluctuating in seven- to eight-year cycles. Why these cycles are occurring

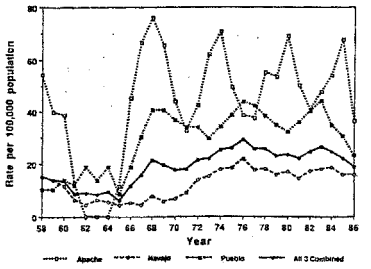

FIGURE 1. THREE YEAR AVERAGE SUICIDE RATES FOR AMERICAN INDIAN CULTURAL GROUPS IN NEW MEXICO, 1958–1986

TABLE 1 Three Year Average Crude Suicide Rates (per 100,000) by American Indian Cultural Groups in New Mexico, 1979–1986

Year	Apache	Navajo	Pueblo	All three combined
1979	53.4	15.9	34.7	23.0
1980	69.0	17.1	32.3	23.6
1981	50.1	14.5	36.2	22.1
1982	40.7	17.2	40.3	24.7
1983	47.6	18.2	44.1	26.7
1984	54.0	18.7	34.8	24.7
1985	67.6	15.8	30.6	22.1
1986	36.5	15.8	23.2	18.8

is unclear. What is clear from this figure is that suicides had either stabilized or declined for all three groups by the mid 1980s. It is possible that the Apache and Pueblo groups are on the downward side of a cycle and that this is just a temporary improvement. If this is the case, suicide rates can be predicted to start increasing in these groups in the next few years.

The three cultural groups have maintained their positions with regard to suicide rates throughout the entire 31-year period. The Apache have the highest rates, the Pueblo the second highest, and the Navajo the lowest rates.

While three-year average rates may be useful for comparing the three Indian cultural groups who have similar age distributions in their population structures, age-adjusted rates are necessary to compare these rates with US rates, since the Indian populations are substantially younger than the US population. Figure 2 and Table 2 show a comparison of age-adjusted suicide rates for the Apache, Navajo, and Pueblo groups, as well as the US for three time periods between 1957 and 1987. One can see the rise in suicide rates for all three Indian groups from the period 1957–1968 to 1969–1979 (Apache: +45%; Navajo: +100%; Pueblo: +87%) and a decline for all three groups from 1969–1979 to 1980–1987 (Apache: −18%; Navajo: −11%; Pueblo: −29%). The decline is not as sharp as the rise, but it is evident. During these three time periods, US rates stayed about the same and, with the exception of the Navajo in the earliest time period, were lower than the suicide rates for all three cultural groups.

Mortality ratios are very useful for comparing the Indian suicide rates to the US rates. Table 3 shows that age-adjusted suicide rates for all three Indian cultural groups in the designated time periods were higher than the US rates, with the exception of the Navajo rate in the earliest time period. Although a slight decrease in ratios is evident from the period 1969–1979 to 1980–1987, Indian rates are still 1.6 to 4.2 times the US rates in the most recent time period.

The above findings suggest some good news, i.e., the suicide rates seem to be stabilizing or decreasing for all three Indian cultural groups. The bad news, however, is that the rates are still much too high and that some of these declines may be temporary.

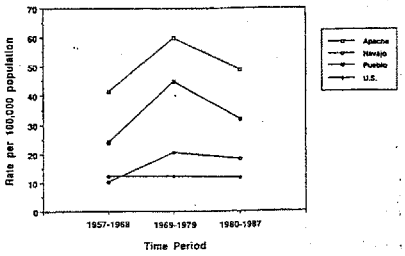

FIGURE 2. AGE-ADJUSTED SUICIDE RATES FOR APACHE, NAVAJO, AND PUEBLO INDIANS AND THE US FOR THREE TIME PERIODS FROM 1957–1987

TABLE 2 Age-Adjusted[a] Suicide Rates (per 100,000) for the Apache, Navajo and Pueblo Indians in New Mexico for 1957–1968, 1969–1979 and 1980–1987

	Age-adjusted rates			% change over previous period	
	1957–1968	1969–1979	1980–1987	1969–1979	1980–1987
Apache	41.3	59.8	48.8	+45	−18
Navajo	10.2	20.4	18.2	+100	−11
Pueblo	24.0	44.8	32.0	+87	−29
U.S.	12.1[b]	12.2[c]	11.6[d]	+1	−5

[a] Age-adjusted rates based on US 1940 standard population.
[b] Age-adjusted rate for 1963.
[c] Age-adjusted rate for 1974.
[d] Age-adjusted rate for 1984.

Since suicide rates in the West are known to be higher than US rates in general, it is useful to compare Indian and non-Indian rates in the state to see if the higher rates observed for American Indians as compared to the general US population may merely be a reflection of regional differences.

It is apparent in Table 4 that suicide rates for the total American Indian population in New Mexico are substantially higher than New Mexico Hispanic whites and slightly higher than non-Hispanic whites for the four time periods reported. In the latest years, the overall rates for all three groups seem to be converging. The suicide rates for American Indian males, however, are clearly higher than the rates for non-Hispanic and Hispanic whites, while the suicide rates for female Indians are generally lower than the rates for females in the other two ethnic groups, especially in the later study years.

Another way to look at the impact of regional differences is to compare rates by counties as was done by Levy and Kunitz (1987) in Arizona. If rates of suicide for Indians are truly higher than rates for non-Indians and not just a reflection of regional differences, then suicide rates should be higher for those counties with larger Indian populations. The data in Table 5 are somewhat supportive of this hypothesis. Table 5 reports suicide rates for three time periods for all New Mexico counties with populations above 10,000 or with Indian populations over 5% for 1980 through 1987. Many of the counties with sub-

TABLE 3 Mortality Ratios for Age-adjusted* Suicide Rates for Apache, Navajo, and Pueblo Indians in New Mexico for 1957–1968, 1969–1979, and 1980–1987; and US for 1963, 1974, and 1984

	1957–1968	1969–1979	1980–1987
Apache to U.S.	3.4	4.9	4.2
Navajo to U.S.	0.8	1.7	1.6
Pueblo to U.S.	2.0	3.7	2.8

* Age-adjusted rates based on US 1940 standard population.
Sources: US data from *US Vital Statistics, Annual Reports* 1963, 1974, and 1984, Vol. I, Part A, Mortality.

TABLE 4 Age-Adjusted* Suicide Rates (per 100,000) in New Mexico by Sex and Ethnic Group, 1977–1989

Sex and ethnic group	1977–1979	1981–1983	1984–1986	1987–1989
Total population				
Non-Hispanic white	23.7	21.3	19.3	21.6
Hispanic white	16.2	16.1	17.2	21.1
American Indian	27.8	21.9	22.3	23.9
Male				
Non-Hispanic white	36.9	33.4	30.0	32.8
Hispanic white	28.0	26.5	29.2	35.8
American Indian	54.4	43.9	44.4	47.4
Female				
Non-Hispanic white	10.8	9.4	8.9	10.5
Hispanic white	4.9	6.2	5.7	7.1
American Indian	5.0	3.3	3.0	3.8

* Age-adjusted to the United States population of the mid-point year (1978, 1982, 1985, 1988).

Source: *New Mexico Vital Statistics Annual Reports, 1979, 1984, 1987, 1989.*

stantial Indian populations have higher suicide rates than those counties with almost no Indian populations. The rates for Santa Fe and Bernalillo counties are higher than might be expected based on the percent of population that is Indian, probably because they contain the more urbanized areas of New Mexico (the cities of Santa Fe and Albuquerque, respectively) and urban areas tend to have higher suicide rates. Also note that suicide rates for most counties in New Mexico are above the national suicide rates.

The final way we explored the impact of region is by comparing Indian and non-Indian suicide rates within each county for the three time periods. (See Table 6.) In general, counties with Apache and Pueblo Indian groups have higher suicide rates for Indians than non-Indians. For counties with a substantial Navajo population, the Indian rates are usually about equal to or lower than the non-Indian rates. In the more urban counties, non-Indian rates tend to be higher. Finally, most non-Indian suicide rates as well as Indian suicide rates are higher than rates for the general US population.

From the above findings, it appears that at least part of the difference between American Indian suicide rates in New Mexico and national suicide rates may be due to regional variation. In general, Indian rates appear to be higher than non-Indian rates for many counties in New Mexico although the differences are not usually great and there are some exceptions. Suicide rates for non-Indians as well as Indians are quite consistently above national rates in the counties we explored. Differences in suicide rates for the counties also are influenced by the particular tribal groups residing in the counties.

In addition to comparing suicide rates among the Apache, Navajo, and Pueblo, demographic variables of sex, age, marital status, veteran status, occupation, birth state, and residence will also be compared.

Demographic Variables

SEX. American Indian suicide in New Mexico continues to be predominantly a male phenomenon. The percentages of male suicides are even higher in 1980–1987 than in the earlier years (Apache: 93.8%; Navajo: 90.0%; Pueblo: 94.5%). The percent male increased from 89.8% in 1957–1979 to 92.2% in 1980–1987. The male to female ratios are 14.9:1 for the Apache, 9:1 for the Navajo, and 17.2:1 for the Pueblo, with an overall sex ratio of 11.8:1 compared to 8.8:1 in the earlier years. These

TABLE 5 Suicide Rates (per 100,000) and Racial Distribution by Selected Counties in New Mexico for 1980–1983, 1984–1987, and 1980–1987

County	1980–1983	1984–1987	1980–1987	Percent Indian	Percent Hispanic	Percent Anglo
McKinley	22.5	19.7	21.0	65.7	12.5	20.3
San Juan	17.0	15.5	16.2	33.0	11.4	54.6
Sandoval	14.1	18.0	16.3	27.3	27.3	43.9
Cibola	*	16.5	*	24.9	38.7	35.5
Valencia	22.5	20.6	21.7	14.1	43.5	41.2
Rio Arriba	27.4	26.1	26.7	11.4	73.3	14.5
Taos	17.3	21.9	19.7	6.4	68.8	23.9
Otero	16.3	19.4	17.9	4.8	21.3	67.0
Santa Fe	19.3	23.4	21.5	2.8	55.0	40.8
Bernalillo	19.7	19.6	19.7	2.7	36.4	56.9
Dona Ana	11.4	13.9	12.8	0.8	51.8	44.5
Chaves	19.3	15.8	17.5	0.6	30.4	66.1
Lea	22.1	10.9	16.4	0.5	21.2	73.1
Curry	8.8	13.3	11.0	0.4	19.2	71.6
Eddy	15.4	20.5	18.0	0.3	30.6	66.9

* Prior to 1982 Cibola County data were included with Valencia County.

Sources: Suicides per county and county population figures provided by Vital Statistics Section of the New Mexico Health and Environment Department. Racial distributions by county from *New Mexico Selected Health Statistics*, 1985.

TABLE 6 Suicide Rates (per 100,000) for Indians and Non-Indians by Selected Counties in New Mexico, 1980–1983, 1984–1987, and 1980–1987

County	1980–1983	1984–1987	1980–1987	Resident tribal groups in county
McKinley				
Indian	22.0	20.4	21.2	Zuni, main reservation Navajo
Non-Indian	23.6	18.3	20.9	
San Juan				
Indian	10.3	12.3	11.4	Main reservation Navajo
Non-Indian	20.3	17.0	18.6	
Sandoval				
Indian	20.7	20.0	20.3	Cochiti, Jemez, Sandia, San Felipe,
Non-Indian	11.6	17.3	14.8	Santa Ana, Santo Domingo, Zia
Cibola				
Indian	*	51.6	*	Acoma, Laguna, Ramah
Non-Indian	*	8.3	*	
Valencia				
Indian	20.3	39.0	24.2	Acoma, Laguna, Ramah**
Non-Indian	21.6	19.9	20.8	
Rio Arriba				
Indian	43.6	40.3	41.9	San Juan, Santa Clara, Jicarilla
Non-Indian	25.3	24.2	24.7	
Taos				
Indian	38.6	0.0	18.6	Picuris, Taos
Non-Indian	15.8	23.4	19.8	
Otero				
Indian	11.3	31.0	21.6	Mescalero
Non-Indian	16.6	18.8	17.7	
Santa Fe				
Indian	11.5	31.0	21.8	Nambe, Pojoaque, San Ildefonso,
Non-Indian	19.5	23.2	21.5	Tesuque
Bernalillo				
Indian	15.0	13.8	14.4	Isleta, Canoncito
Non-Indian	19.9	19.7	19.8	
Dona Ana				
Indian	0.0	25.9	14.1	
Non-Indian	11.5	13.8	12.8	
Chaves				
Indian	0.0	0.0	0.0	
Non-Indian	19.4	15.9	17.6	
Lea				
Indian	0.0	77.8†	39.9†	
Non-Indian	22.2	10.6	16.3	
Curry				
Indian	0.0	0.0	0.0	
Non-Indian	8.8	13.3	11.1	
Eddy				
Indian	0.0	0.0	0.0	
Non-Indian	15.4	20.6	18.0	

* Prior to 1982 Cibola County data were included with Valencia County.

** Prior to 1982 when Cibola County came into existence.

† These rates are very misleading and are based on one suicide in 1985.

Sources: Suicides per county and county population figures provided by Vital Statistics Section of the New Mexico Health and Environment Department. County locations of Indian resident tribal groups from State of New Mexico map.

TABLE 7 Suicides by Cultural Group and Five Year Age Groups for American Indians in New Mexico, 1980–1987

Age	Apache (n = 16) %	Navajo (n = 90) %	Pueblo (n = 73) %	All three combined (n = 179) %
5–9	0.0	1.1	0.0	0.6
10–14	0.0	3.3	0.0	1.7
15–19	12.5	8.9	30.1	17.9
20–24	31.3	25.6	23.3	25.1
25–29	31.3	23.3	20.5	22.9
30–34	6.3	10.0	11.0	10.1
35–39	12.5	6.7	5.5	6.7
40–44	0.0	8.9	4.1	6.1
45–49	6.3	1.1	2.7	2.2
50–54	0.0	6.7	0.0	3.4
55–59	0.0	2.2	1.4	1.7
60–64	0.0	1.1	1.4	1.1
65 and above	0.0	1.1	0.0	0.6
	100.2	100.0	100.0	100.1

Note: Percentage columns totaling values other than 100% are due to rounding.

figures compare to a ratio of 3.3:1 in the general US population (Rosenberg et al. 1987:423).

AGE. As well as remaining a male phenomenon, American Indian suicide in New Mexico remains a phenomenon of the young. The age range in this study is 9–70 years with a median age of 25 years for all New Mexico Indians (Apache: 25 years; Navajo: 26.5 years; Pueblo: 24 years). As seen in Table 7, 62% to 75% of all suicides occurred among individuals under 30 years of age for all three Indian groups. In general, the percent of total suicides has increased for the very young and those in their 20s and 30s, and decreased slightly for teens and those 40 years and older from the earlier to the later time periods. The Navajo show the most dispersed age pattern of the three groups.

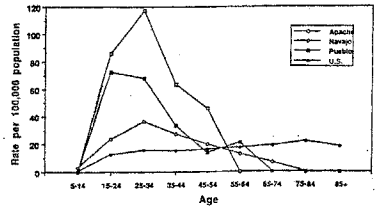

FIGURE 3. AGE-SPECIFIC SUICIDE RATES FOR APACHE, NAVAJO, AND PUEBLO INDIANS AND THE US, 1980–1987

Figure 3 and Table 8 illustrate the age-specific suicide rates for the three Indian groups and for the US for 1980–1987.[2] Suicide rates peak for all three Indian groups in either the 15–24 year age range or 25–34 year age range. This is quite different from the US rates, which gradually increase with age until 75–84 years. Most suicide rates of all three Indian groups for age groups under 55–64 years exceed US rates. Most US rates, however, are higher than Indian rates for age groups older than 64. This pattern can also be seen with the mortality ratios reported in Table 8. In the age group 15 to 24 years, Indian rates are 1.9 to 6.9 times higher than the overall US population. A similar pattern is also found in age groups 25–34 and 35–44. Indian rates only begin to approach overall US rates by ages in the late 40s and early 50s.

MARITAL STATUS. Patterns of marital status for suicides have become more uniform for the three cultural groups over time. In the period 1980–1987, at least half of the suicides in each group were committed by individuals who were single (Apache: 50.0%; Navajo: 54.4%; Pueblo: 64.4%). This was an increase for the Navajo (21.1 percentage points) and Pueblo (11.4 percentage points), but a decrease for the Apache (25.0 percentage points) since the 1957–1979 study. The percentage of suicides who were married also converged somewhat, as ap-

TABLE 8 Age-Specific Suicide Rates (per 100,000) for Apache, Navajo, and Pueblo Indians in New Mexico for 1980–1987 and US Rates for 1984

Age	1980–1987 Apache	1980–1987 Navajo	1980–1987 Pueblo	US 1984	Mortality ratio: Apache to US	Mortality ratio: Navajo to US	Mortality ratio: Pueblo to US
5–14	0.0	3.0	0.0	0.7	0.0	4.3	0.0
15–24	86.2	23.7	72.3	12.5	6.9	1.9	5.8
25–34	117.3	36.4	67.7	15.5	7.6	2.3	4.4
35–44	63.1	27.4	33.2	15.1	4.2	1.8	2.2
45–54	45.6	19.8	13.7	16.2	2.8	1.2	0.8
55–64	0.0	12.9	20.8	17.3	0.0	0.7	1.2
65–74	0.0	6.4	0.0	18.8	0.0	0.3	0.0
75–84	0.0	0.0	0.0	22.0	0.0	0.0	0.0
85+	0.0	0.0	0.0	18.4	0.0	0.0	0.0

Sources: US data from *US Vital Statistics, Annual Report 1984*, Vol. I, Part A, Mortality.

proximately one-third of each group in the latest period was married (Apache: 37.5%; Navajo: 33.3%; Pueblo: 28.8%). This was a decrease for the Navajo (17.1 percentage points) and Pueblo (9.3 percentage points) and an increase for the Apache (16.1). When looking at marital status by sex, all subgroups were more likely to be single than married, and very few were likely to be separated, divorced, or widowed. Much of this pattern is explained by the young age at suicide.

VETERAN STATUS. As in the earlier period, most Indians in each cultural group were non-veterans (Apache: 87.5%; Navajo: 88.8%; Pueblo: 83.3%). These percentages are somewhat higher than in the earlier period (75.0% vs. 86.4%) and probably reflect national changes in requirements for military service rather than anything specific to the Indian groups. Reporting has improved greatly for this variable over time, as the percentage of death certificates having missing data on veteran status declined from 21.1% in the earlier period to 1.1% in the later period.

OCCUPATION. In general, reporting of occupation remains unreliable. It should be noted, however, that there was a 4.2 percentage point decrease in suicides identified as students from the earlier to the later time periods.

BIRTH STATE AND RESIDENCE. Patterns of birth state and residence for 1980–1987 also are similar to patterns from 1957–1979. The majority of American Indian suicides in this study were born in New Mexico (86.5%) with an additional 10.1% born in Arizona. Most of those born in Arizona are Navajo whose main reservation spans Arizona and New Mexico. The majority of individuals committing suicide lived either on the reservation or in areas characterized by reservation conditions, i.e., off-reservation Indian communities or the Navajo checkerboard area (Apache: 93.8%; Navajo: 65.9%; Pueblo: 93.2%). This pattern represents a decrease for the Apache (6.2 percentage points) and Navajo (14.3 percentage points), and an increase for the Pueblo (6.4 percentage points). About one-third of the Navajo who committed suicide lived off the reservation, but that is probably because more Navajo live off the reservation (even while remaining in New Mexico) than do Apache and Pueblo. In 1980, 77.7% (83,432) of all Indians in New Mexico lived on a reservation or on trust lands (US Bureau of Census 1984).

In addition to these demographic variables, comparisons of situational variables of method, place of injury, place of death, other significant conditions, calendar and time variables will be made.

Situational Variables

METHOD. In the 1980s, Indians in New Mexico continued to use methods such as firearms and hanging, which almost always result in death, to commit suicide. As can be seen in Table 9, firearms were the most frequently used method for all groups and both sexes with two exceptions. These exceptions are Apache males for whom hanging was the method of choice, and Navajo females who favored overdose/poisoning. Compared to 1957–1979 data, hangings are occurring more frequently now than in the past (38.5% vs. 22.2% for all three groups combined), and Navajo women, rather than Pueblo women, are more likely to commit suicide by overdosing or ingesting poison. About 57% of suicides in the general US population in 1980 were due to firearms with the following breakdown for males and females: firearms (63.1% vs. 38.6), hanging (14.6% vs. 10.9%), overdosing or ingesting poison (6.5% vs. 26.9%) (Rosenberg et al. 1987:427,431).

PLACE OF INJURY. Reporting of place of injury on death certificates during 1980–1987 improved from the earlier study period. In the later period, only 9.6% of the certificates were missing this information, as compared to 21.8% in the earlier study. The most common place of injury remains the same with 71.8% of the total number of suicides occurring in or around a home or residence (Apache: 73.3%; Navajo: 65.9%; Pueblo: 79.1%). This pattern reflects an increase for the Apache (6.6 percentage points) and Navajo (9.6 percentage points), and a very slight decrease for the Pueblo (1.9 percentage points).

PLACE OF DEATH. Most New Mexico Indians who committed suicide died in areas characterized by reservation conditions (Apache: 81.3%; Navajo: 54.2%; Pueblo: 75.3%). The percentage point difference from 1957–1979 to 1980–1987 is small for all groups (Apache: −1.5 percentage points; Navajo: −6.0 percentage points; Pueblo: +7.8). More suicide victims died off reservations than were injured off reservations (all three groups combined: 34.3% vs. 20.8%). This is primarily due to the fact that some individuals were transported to hospitals in cities after sustaining their injuries and died in the hospitals.

TABLE 9 Suicides by Cultural Group, Sex, and Method for American Indians in New Mexico, 1980–1987

	Apache		Navajo		Pueblo		All three combined	
	Male (n = 15)	Female (n = 1)	Male (n = 81)	Female (n = 9)	Male (n = 69)	Female (n = 4)	Male (n = 165)	Female (n = 14)
Method	%	%	%	%	%	%	%	%
Overdose/poisoning	0.0	0.0	6.1	66.7	0.0	0.0	3.0	42.9
Hanging	60.0	0.0	38.3	22.2	37.7	25.0	40.0	21.4
Firearms	40.0	100.0	53.1	11.1	60.9	75.0	55.2	35.7
Other	0.0	0.0	2.5	0.0	1.4	0.0	1.8	0.0
	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Note: Percentage columns totaling values other than 100% are due to rounding.

OTHER SIGNIFICANT CONDITIONS. On only 9% of the death certificates included in this study were "other significant conditions" noted. It is unclear whether this is a result of "other significant conditions" not being present or not being recorded. When other conditions were mentioned, however, 94.1% mentioned substance abuse (particularly alcoholism) and/or depression. While not surprising, this finding suggests that the relationship of these conditions to suicide should be explored in greater depth in these Indian groups.

CALENDAR AND TIME VARIABLES. Although there will always be some cases for which the day of injury is unknown for suicides, the percentage of death certificates with these data listed as unknown or missing improved from 17.6% in 1957–1979 to 10.1% in 1980–1987. Because of the missing data for day of injury of suicides, researchers sometimes substitute day of death for day of injury. While this information is reported on all death certificates, the day of death may be different from the day of injury if the person does not die immediately from the injury. Both figures will be reported for this study and compared.

Few patterns were observed with the calendar variables in the study from 1957–1979. There was some variation between the three cultural groups in 1957–1979 with regard to month of injury, but about one-quarter of the suicides occurred during each season of the year for all three groups combined. In 1980–1987, some variation could be seen. The highest percentages of suicidal injuries for all three groups combined occurred in the summer (June–August: 28.4%) and fall (September–November: 27.8%) followed by winter (December–February: 25.3%) and spring (March–May: 18.5%). The highest percentages of injuries by season for individual cultural groups for 1980–1987 was winter for the Apache (40.0%) and Pueblo (29.2%), and summer for the Navajo (30.5%). Season of death followed the same pattern found for season of injury. These findings are different from the general US pattern, in which spring has the highest frequency of suicides (Holinger 1987:50).

The highest percentages of suicidal injuries by month during 1980–1987 occurred in January for the Apache (20.0%), and August for the Navajo (15.9%). September and December tied at 13.8% for the Pueblo. A similar pattern was found for month of death (Apache: January, 18.8%; Navajo: August, 15.6%; Pueblo: January, 12.3%, September, 12.3%, December, 12.3%). The months during which more suicides were committed and deaths occurred correspond to the start of school and the holiday months.

Approximately 50% of the suicide injuries and deaths occurred in the first half of the month (Day 1–15) and 50% in the second half of the month (Day 16–31) with some variations by actual day for each cultural group. This was also true in the previous period of study (1957–1979). The only significant variations from this were: 1) the Apache in the earlier time period, when 59.1% of the injuries and 70% of deaths occurred in the second half of the month; and 2) the Navajo from 1980–1987, with 58.9% of the deaths occurring in the first half of the month.

Many of the suicide injuries and deaths occurred on Friday, Saturday, and Sunday, as expected, during both the earlier and later periods. From 1957–1979, 50% of the Apache and Navajo suicide injuries and 51.8% of the Pueblo injuries occurred on these three days. The percentages are somewhat higher now (Apache: 66.7%; Navajo: 50.6%; Pueblo: 56.9%), indicating a greater clustering just before and during the weekends. Similar patterns were found when day of death was limited to Friday, Saturday, and Sunday (1957–1979: Apache, 50.0%; Navajo, 47.0%; Pueblo, 54.7%; 1980–1987: Apache, 62.5%; Navajo, 44.4%; Pueblo, 53.4%). For all three groups in both time periods, both suicide injuries and deaths occurred most frequently on either Friday, Saturday, or Sunday. This is different from the pattern in the general US population of suicides, which occur most frequently on Mondays (Holinger 1987:50).

Reporting of the time of injury is even less complete than reporting of the day of injury for this sample. The percentage of missing data rose from 28.9% during 1957–1979 to 36.9% during 1980–1987. Because of the large amount of missing data, no analysis will be made of this variable.

Individual Reservations

Great variation in suicide rates occurred among the individual reservations in New Mexico for the time period 1980–1987 (see Table 10). This was also true for the period 1957–1979. Rates for some tribal groups have increased in the 1980s and decreased for others. Nevertheless, the current rank

TABLE 10 Suicide Rates (per 100,000) and Frequencies for Reservations in New Mexico Ranked According to Rate for 1957–1987 by Two Time Periods: 1980–1987 (8 Year Average) and 1957–1987 (31 Year Average)

	1980–1987		1957–1987	
Reservations	Rate	*n*	Rate	*n*
Nambe	118.3	2	76.5	4
Jicarilla	71.1	12	59.7	31
Picuris	91.0	1	52.8	2
Laguna	56.2	17	48.6	48
Cochiti	37.4	2	44.0	7
Isleta	32.7	8	38.4	28
Zia	43.2	2	34.3	5
Zuni	38.4	21	33.7	56
Santa Ana	28.2	1	33.6	4
Mescalero	23.1	4	29.1	15
Taos	10.2	1	29.0	11
Canoncito	13.7	1	26.0	6
San Juan	13.1	1	24.7	6
Acoma	29.2	6	19.7	14
Alamo	36.8	4	18.6	5
San Felipe	12.5	2	18.1	8
San Ildefonso	23.4	1	17.4	2
Jemez	22.6	3	16.1	7
Ramah	16.5	2	14.8	5
Tesuque	47.8	1	14.4	1
Santa Clara	19.8	1	14.2	3
Other Navajo	15.1	83	13.0	191
Santo Domingo	10.1	2	4.9	3
Pojoaque	0.0	0	0.0	0
Sandia	0.0	0	0.0	0

ordering of tribes for 1957–1987 stayed very similar to the rank ordering for 1957–1979, with all but three reservations remaining within three positions of their original ordering. Two Pueblo reservations, Pojoaque and Sandia, have not had any reported suicides during the 31-year period covered.

Table 11 is a more detailed version of a table in the earlier publication showing the crude suicide rates for Pueblo tribes in New Mexico having populations over 1,000 (Van Winkle and May 1986:305). This table includes results reported by Levy for 1954–1962 (1965:313) and five time periods from the data analyzed by the authors. In 1957–1979, a totally consistent pattern was reported (Van Winkle and May 1986:305–306), showing that the acculturated Pueblos had the highest rates, followed by the transitional Pueblos, and the traditional Pueblos. This table shows much more diversity in rates over time. It appears that the acculturation theory (the more contact with the white world, the higher the rates), does not apply as consistently to these groups in recent years. The rates for 1980–1987 do not as consistently represent the Pueblos with the highest level of acculturation as having the highest rates. Fluctuation over time is very evident on most reservations. Some of this fluctuation may be due to the small population numbers. In the entire 31-year period, however, the rates still seem to support the importance of acculturation to suicide. The length of time that acculturation affects a community needs to be examined. It may be an effect of great importance only for several decades.

Discussion

Using data from 1980–1987, this updated study of American Indian suicide in New Mexico has shown a continuation of many patterns of suicide found in the earlier study covering 1957–1979. Suicide mortality among the Apache, Navajo, and Pueblo of New Mexico continues to involve predominantly young males who primarily live and die on the reservation. Age-adjusted suicide rates for all three groups remain above US rates, and age-specific rates remain above US rates for most age groups under the age of 55 years. Indian rates of suicide also remain higher than other ethnic groups in New Mexico, but part of the difference in suicide rates between New Mexico Indians and the general US population may be due to regional variation.

Most of the Indians who commit suicide continue to be single non-veterans who use methods that are almost always fatal: firearms or hanging. While firearms still are used most frequently by all three groups combined, the percentage of deaths by hanging has increased.

While some seasonal variations can be seen among the groups, the months during which most suicides have occurred correspond to the beginning of the school year and the holiday months. Over half of the suicides have occurred on Friday, Saturday, and Sunday. A comparison of data for calendar variables yielded similar results regardless of whether date of injury or date of death was used. Since most suicides were committed using methods that resulted in immediate death, the majority of individuals in this sample died on the same day that they were injured. For both time periods, 72% of the total sample had identical dates of injury and death. For that portion of the sample for which dates of injury were known, that correspondence was even greater (1957–1979: 87%; 1980–1987: 80%). It also should be noted that the information on death certificates in New Mexico is generally more complete now than in the past.

One of the important contributions of this study is the identification of suicide cycles for the Apache and Pueblo groups. Three-year average rates seem to show 5–6 year cycles (from peak to peak) for the Apache and 7–8 year cycles for the Pueblo. Although suicide rates seem to be stabilizing or declining for all three groups, the decline for the Apache and Pueblo may be just the downward curve of another cycle.

Why these cycles are occurring is uncertain. One possibility is that clustering, i.e., one suicide periodically triggering a rash of imitative suicides (Bollen and Phillips 1982, Phillips 1974), may be contributing to the peaks in these cycles. Imitative behavior has been found and documented among US youths (Gould, Wallenstein, and Davidson 1989; Gould, Wallenstein, and Kleinman 1990; Gould et al. 1990), and in Micronesia, an area that has experienced a great deal of culture change since the end of World War II (Rubenstein 1983). Suicide clusters among some Indian groups also have been well documented recently (Bechtold 1988; Davis and Hardy 1986;

Table 11 Crude Suicide Rates (per 100,000) and Level of Acculturation for Pueblo Tribes in New Mexico with Populations over 1,000 for 1954–1962, 1957–1965, 1966–1972, 1973–1979, 1980–1987, and 1957–1987

	1954–1962[a]	1957–1965	1966–1972	1973–1979	1980–1987	1957–1987	Level of acculturation[b]
Laguna	16.9	27.7	60.5	55.7	56.2	48.6	Acculturated
Isleta	22.2	24.0	57.6	44.8	32.7	38.4	Acculturated
Taos	16.7	19.0	37.8	52.0	10.2	29.0	Transitional
Zuni	2.8	5.6	30.3	53.7	38.4	33.7	Transitional
San Felipe	0.0	0.0	48.1	19.3	12.5	18.1	Traditional
Acoma	5.0	5.5	6.9	33.3	29.2	19.7	Traditional
Jemez	8.3	18.5	11.7	9.2	22.6	16.1	Traditional
Santo Domingo	6.5	0.0	0.0	6.7	10.1	4.9	Traditional

[a] Rates taken from Levy (1965: 308–318).

[b] Classification also adapted from Levy (1965).

Fox, Manitonabi, and Ward 1984; Long 1986; Tower 1989; Ward and Fox 1977). From anecdotal information and a preliminary review of information from the Office of the Medical Investigator, some suicides in this sample appear to be imitative suicides, to occur in certain families, and to have specific geographic clusterings. Moreover, if imitation can be a factor in mass society in the US insofar as it is perpetuated by news stories and the media (Bollen and Phillips 1982, Phillips 1974), it is likely to be an even greater influence in a small Indian community where individuals have primary ties to and personal knowledge of those who commit suicide (Bechtold 1988, Watson 1969).

In addition to imitative behavior, the cycles identified in this study may be due to other social or economic trends. To explore possible causes of these cycles would entail both further analysis of demographic data (Gould, Wallenstein, and Davidson 1989; Gould, Wallenstein, and Kleinman 1990) as well as psychological autopsies and social, historical, and economic studies of the study populations.

The relative positions of the Apache, Navajo, and Pueblo have remained the same for the various rates from the first to the second study. The Apache have the highest rates followed by the Pueblo and the Navajo. This ranking was explained in part by both the influence of historical/traditional and contemporary social integration and acculturation in the earlier study (Van Winkle and May 1986). The Apache, with the highest suicide rates, is the cultural group characterized by the lowest level of contemporary and traditional social integration, i.e., band level solidarity and high individualism. Acculturation or social change also seems to be an issue in that the Pueblo, who have the highest level of social integration, have higher suicide rates than the Navajo. If social integration were the only important factor, this pattern might be reversed and the Pueblo would have the lowest suicide rates (Durkheim 1951).

Two explanations might possibly explain this discrepancy. First, it may be that the Pueblo tribes elevate their suicide rates through negative sanctions of disapproved behavior by labeling, ostracizing, or otherwise isolating and punishing individuals or families who do not conform to group expectations. This pattern has been described by Levy and Kunitz (1987) for suicide and May et al. (1983) for Fetal Alcohol Syndrome.

Second, acculturation and/or modernization pressure is strong among a number of the Pueblos due to their proximity to cities such as Albuquerque, Santa Fe, and Taos. This factor may elevate the suicide rates among vulnerable subgroups within the more vulnerable Pueblo communities by such means as labeling families and youth in transition.

The data in Table II continue to lend credence to the acculturation argument. By using only Pueblo groups for comparison in Table II, one is controlling somewhat for general cultural patterns and historical/traditional levels of social integration. While there is undoubtedly some variation in levels of integration among the Pueblo tribes, it seems reasonable to assume that they all are more tightly integrated than the Navajo and Apache tribes. Among these similar groups, level of acculturation does seem to explain some of the differences and fluctuations in rates. Where discrepancies in the expected patterns occur, e.g., the high rates for San Felipe for 1966–1972, they may be attributable to short-term phenomena, like imitative behavior. This problem has to be studied further.

Finally, it should be noted that these two explanations are not mutually exclusive. The suicide potential may be both generated by traditional forces within a Pueblo or traditional tribal organization and also exacerbated by acculturation pressure in the more transitional communities.

Perhaps it is not just the level of social integration or acculturation of the community that is important, but the dissonance between the acculturation levels of the individuals committing suicide, their families and/or their communities that accounts for these variations. In a study by Boyce and Boyce (1983:224) describing health changes among Navajo students in a boarding school in Crownpoint, NM, "the absolute degree of incongruity between family and community cultural orientations (regardless of its direction) was associated with an increased risk of significant changes in health" rather than acculturation level of the community or family. As Levy and Kunitz (1987) have reported, acculturation within Hopi families and perceived violation of traditional community norms can influence suicide and other forms of deviance. It is possible, then, that high levels of dissonance or incongruity can predispose individuals to suicide. Further research needs to be conducted to expand our understanding of the applicability of these theories.

An exploration of male and female suicides is warranted from the results of this study. What are the differences between male and female suicides? Why do Indian females have the lowest rates in New Mexico? What are the differences in gender roles and supports for these roles in the community which might contribute to these widely discrepant rates? Indian females are frequently ignored in contemporary studies of Indian suicide and social problems in general (Havighurst 1971, May 1989). In studies conducted in Micronesia, suicide also has been found to be a young male phenomenon. In the communities that experienced the highest rates of suicide, values between adolescents and their parents were more dissonant, and traditional structural supports for male adolescents were absent (Rubinstein 1983). It seems likely that something similar is occurring among New Mexico Indian groups, particularly where social change and acculturation pressures are great.

Finally, the results of this study suggest that alcohol may be a factor in some of these suicides. Other studies also have suggested and/or documented such a connection (André and Ghachu 1975; Berman 1979; Fox, Manitonabi, and Ward 1984; Jarvis and Boldt 1982; Levy 1965; Manson et al. 1989). Certainly this issue should be further explored to uncover the extent and nature of the association.

While this study suggests that there may be hope that the suicide rates are beginning to decline or stabilize for the Apache, Navajo, and Pueblo of New Mexico, this hope is guarded. Rates remain unacceptably high, and young males continue to be particularly at risk. Additional longitudinal, epidemiological and in-depth community studies are needed to monitor the trends, develop a better understanding of the etiology of suicide among these Indian groups, and develop sound prevention programs.

NOTES

[1] A slightly different formula was used to calculate the population figures for the Main Reservation Navajo from 1980–1987. The formula used in the previous study (1957–1979) was a proportion of New Mexico residents of three Navajo service units of the Indian Health Service (Crownpoint: 100%; Gallup: 86.5%; Shiprock: 71.7%). This for-

mula yielded a population of 57,395 in 1979. With improved methods in the 1980 census, we were able to simplify the calculations. The formula used to calculate the population for this study is the total IHS Navajo area population times 40.6%, which yields a population of 58,936 in 1980. Using Navajo service unit figures for 1980 as a check yielded 58,904. Given the small discrepancy, we chose to use the slightly higher population figure for the most conservative rates.

[2] The population distributions used in determining age-specific and age-adjusted rates were calculated in an improved manner from the original article. This procedure was developed to be more culturally sensitive in reflecting the proportion of Indians from the Navajo Area and from the Albuquerque Area of IHS for the years 1970 and 1980. IHS reported population distributions in 1960 by state rather than by IHS Areas so this method could not be used for 1960. The percent distributions of population by age level were determined in the following way:

A. $\frac{\text{19xx Apache + Pueblo population}}{\text{19xx Apache + Navajo + Pueblo population}} = X$ (% Apache/Pueblo)

B. $\frac{\text{19xx Navajo population}}{\text{19xx Apache + Navajo + Pueblo population}} = Y$ (% Navajo)

C. For *each* 5 year age level:
   1. (% Indian males in Albuquerque Area × X) + (% Indian males in Navajo Area × Y) = A (% of Total N.M. Indian males)
   2. (% Indian females in Albuquerque Area × X) + (% Indian females in Navajo Area × Y) = B (% of Total N.M. Indian females)
   3. $A + B$ = % of Total N.M. Indians

The percent distributions derived in this manner were used to determine the population figures used in calculating rates for each age level. Numbers for Tables 4 and 5 from the 1986 article have been recalculated using this modification and are available on request. While some numbers have changed slightly, the overall patterns remain the same.

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13

Durkheim's Suicide Theory and Its Applicability to Contemporary American Indians and Alaska Natives

Philip A. May, PhD and Nancy Westlake Van Winkle, PhD

We don't know if Durkheim ever met an American Indian or Alaska Native; neither do we know if he had ever been among a North American tribal group. But we do know that such experience would have been interesting for him as a social scientist. It certainly has been for us over the past several decades. We are sure, however, that the theoretical foundations which Durkheim put forth would have eventually allowed him to understand a great deal of the behavior which he would have observed among Indians. The following will be an elaboration of this theme.

Durkheim's analysis of the importance of social integration to suicide applies quite explicitly to American Indian groups. The fit between Durkheim's theories and the overall phenomenon of suicide among American Indians is quite good. Examples from tribe to tribe have provided evidence of the broad applicability and the timeless nature of Durkheim's work.

THE MAJOR THEORY

"Suicide varies inversely with the degree of integration of the social groups of which the individual forms a part" (Durkheim, 1951, p. 209). This summary statement provides the theoretical base for analyzing suicide patterns and a number of other self-destructive behaviors among American Indians. As a concise axiom it provides an excellent framework for the analysis of Indian tribal and community structures. The genesis of a variety of types of deviant behavior, such as suicide, homicide, alcohol abuse, and child abuse and neglect can be understood by using Durkheim's theory. Suicide alone, however, will be the major focus of this chapter.

In Europe, Durkheim's observations and data led him to the conclusion that suicide varied in social groups by religion,[1] marital status, and political society (Durkheim, 1951, p. 208). This is also the case among American Indian tribes. Variance in suicide rates in particular, and other types of deviance as well, is based on these same variables. Tribes with particular characteristics and patterns of social, political, religious, and familial organization will generally have high rates of suicide, and those with the opposite structural and integrative characteristics will have lower rates of suicide. The independent variables identified by Durkheim are indeed quite universal, and they do influence American Indian communities even though the actual cultural content of these communities is very different from that of Europe in Durkheim's time. Cutting through ethnocentric values and particular cultural traits to analyze basic social structures allows for useful and productive research and a general understanding.

The level of social integration, Durkheim's most broadly encompassing independent variable, is a key diagnostic tool in any society or community. This is quite true among American Indians. There are over 300 federally recognized tribes today and over 500 Indian communities and Alaska Native villages which have independent political and legal status (United States Census, 1991). Furthermore, there is tremendous diversity among American Indian tribes and communities. The specific cultures and lifeways of various groups of Indians and Alaska Natives are highly diverse. The Cherokee of the Southeast woodlands were, and still are, vastly different from the Lakota (Sioux), Cheyenne, Blackfeet, Shoshone, and Arapaho of the Plains. Their language, material culture, and various values and beliefs were very different in the past, and differences persist today. Similarly, the Pueblo, Navajo, and Apache, who all live in the Southwestern United States, are very different from one another in their history, culture, language, lifeways, and even modal personalities and individual characteristics. The lifeways of various groups or bands of Alaska Natives also run the gamut of diversity.

In spite of these differences in culture and content, each tribal and native society contains certain basic elements of social structure which can be identified and analyzed in a consistent and insightful manner. Each has a level of social integration which can be the cornerstone of analysis using social science methods and theories pioneered by Durkheim to understand patterns of behavior and to implement solutions for problems.

Many anthropologists, such as Ruth Benedict (1934), recognized this diversity of lifeways. Yet she also analyzed some of the common and most influential elements of life such as styles of childbearing, conflict resolution, social control, and the integrative importance of custom. More generally, several generations of anthropologists were engaged in the noble enterprise of describing the range of diversity and uniqueness of individual American Indian cultures and aggregating them by common social and cultural types (Josephy, 1968; Hodge, 1981; Spencer and Jennings, 1977).

The focus on the uniqueness of each tribal culture can only go so far in

promoting the type of understanding of social behavior which is most useful for proposing practical and transferable solutions in areas such as public health and the prevention of behavioral health problems. The study and understanding of suicide among Indians has had to go beyond the unique patterns among each tribe as they exist in isolation. The common social elements among the different tribal and community groups must be analyzed and utilized for a more general and applied understanding. Durkheim's work, *Suicide,* provides an excellent framework for understanding and a vehicle for intervention and solutions. By beginning with the overall statement with which this section began, that suicide varies inversely with social integration, one can work efficiently and successfully to unravel and analyze the magnitude and patterns of suicide in a tribal community. Such an understanding also applies to many of the personal paths to suicide which are traversed by individual Indians of these groups.

SOCIAL INTEGRATION, SUICIDE AND INDIANS

Traditional Integration

Among American Indian tribes there is a variety of different levels of social integration which ranges from extremely high (tight) to extremely low (loose). Over the years anthropologists have provided the observations, data, and categories necessary for classifying different American Indian tribes into high, medium, and low levels of traditional social integration (Spencer and Jennings, 1977; Hodge, 1981). This facilitates general understanding regarding the pattern of suicide.

In the last three decades of deviance research among Indians, the concept of integration has been utilized by a number of researchers. The most influential proponents have been Jerrold Levy, Steven Kunitz, and their colleagues (see for example Levy, 1965; Levy, et al., 1969; Levy and Kunitz, 1971; Levy and Kunitz, 1974). In these works, social integration refers to the processes which cement a collection of individuals into a large social group. It is also used to refer to the individual's symbolic and structural attachment to larger groups such as the family, religious, and political groups, and also to the overall tribe, ethnic group, state, or nation. This concept is directly from Durkheim, Weber and the early European sociologists (Gould and Kolb, 1964, pp. 656-657, 661-662).

In *low-integration* societies the individual is a member of fewer permanent groups and, in particular, fewer large groups. In such tribal societies the main social units are less likely to place strong and clear mandates of conformity (prescriptions and proscriptions or integration and control) on the individual. The individual has more freedom to define his or her own behavior. Norms are less deterministic. Formal social organization is usually limited to the family or band level in most low-integration tribes, and higher level institutions are weak or nonexistent in their influence and control.

In *high-integration* societies the opposite is true. The individual is expected to conform to the more formal and relatively clear mandates of the entire political organization of the community. In most or all of the social groups to which the individual belongs (e.g., family, religious, and community groups), the contribution to the overall community (tribal) stability is relatively explicit. Norms and mores permeate all parts of society, from dress to gender and occupational roles.

High- and low-integration societies are, essentially, ideal types. That is, Durkheim's work indicates that no society is completely one type or the other. The difference in contemporary social groups is also a matter of degree. For example, Durkheim used the Catholic Church with its hierarchical structure and extensive formal rules and procedures as an example of a high-integration group. Protestant denominations of Europe were used as an example of a lower-integration group. Durkheim obviously set the tone of our research with his general theory of social integration, and we apply it to tribal groups. Different tribal groups approach the ideal types to a degree, and the relative degree of integration becomes a useful independent variable.

In our contemporary Indian studies of suicide, Plains culture tribes of Montana, North and South Dakota, Nebraska, Wyoming, New Mexico, and western Oklahoma, among others, represent low-integration societies. Band-level social structure was generally the most binding form of social control within these low-integration societies. A number of medium-integration groups also exist such as the Navajo, Pima, Tohono O'odam (Papago) of the Southwest. In the medium-integration tribes band level organization is augmented by broader levels of control at the community level (e.g., clan and communal groups organized around larger, rather permanent group-supporting functions). The Pueblo tribes of New Mexico and Arizona represent high-integration societies.

Modernization and Acculturation

In studies of American Indian suicide and deviance, cultural types and tribes can be classified by the *traditional* level of social integration. A rough idea of the level of suicide and other deviance can then be anticipated for the tribe. Traditional in this case refers to the integration characteristics present prior to major and relatively constant contact with peoples from Europe—Hispanic, English, or French society.

But there is another influential and confounding factor. With American Indian tribes social change in the form of modernization has led to variations in the social integration of particular reservations. Some American Indian communities have, and are currently undergoing, rapid change from the effects of modern, western mainstream cultural influences. At the same time, other

communities, because of geographic and social isolation (some of it self-imposed traditionalism), have not changed as rapidly or as radically. Among those tribes where change has been substantial, traditional social control and social integration have generally been weakened.

In the earlier years of contemporary suicide and deviance literature on Indians (see Bynum, 1972; Dizmang, 1967; Minnis, 1963; Resnick and Dizmang, 1971), most articles talked only of social disorganization among Indian cultures as the determining factor of suicide and deviance levels. But later works, such as those by Levy and Kunitz cited above, emphasized the persistence of traditional cultural influences and patterns as well. Later in our own works (May, 1987, 1989a; May and Van Winkle, 1993; Van Winkle and May, 1986, 1993) the dual influences of both traditional culture and modern change and acculturation have been demonstrated and emphasized.

The current understanding of these integrational influences can be capsulized as follows. Tribes that have had high traditional social integration and have undergone little disorganization from modernization,[2] have been characterized as having very low rates of suicide. On the other hand, tribal communities which had historically high integration and which are experiencing rapid change, have rates which are substantially elevated. The same can be said within the other two categories of medium and high traditional integration. An elevation in suicide rates is generally caused by social change and modernization. This elevation can be substantial enough to cause an overlap or overtaking of suicide rates from one category of integration to the next. For example, a high-integration tribe's suicide rate can rise beyond that of a medium-integration tribe when undergoing rapid change.

Some illustrative data from our Southwestern studies are in order. As Table 1 indicates, the rate of suicide between cultural groups in New Mexico does not vary substantially from one group to the next. The low-integration tribes, the Apaches (Southwestern Plains culture), have the highest average suicide rates and the greatest fluctuation over time.[3] In the earlier years of data the pattern of suicide was exactly as Durkheim's work would have predicted. At that time traditional tribal culture was the predominant influence on the rates. In the 3-year-average rates for 1958-59, the low-integration tribal culture (Apache) had the highest suicide death rate. The highest-integration culture (the Pueblo) had the lowest rate, and the medium-integration culture (the Navajo) was intermediate in rate. Thus, the inverse relationship holds exactly in these years as traditional integration is the less affected by modernization.

Later, there are major exceptions, however. In more recent years, the high-integration culture (the Pueblo tribes) had higher suicide rates than the Navajo (medium integration). This deviation in the overall Pueblo rate from the generalized expectation is due to the rather rapid change in integration among a number of the Pueblo tribes which was brought about by the acculturation of individuals and groups and the pressures of modernization.[4] The forces of modernization and acculturation have been influential on

Table 1.

Age-Adjusted[1] Suicide Rates (per 100,000) for the Apache, Navajo and Pueblo Indians in New Mexico for 1957-1968, 1969-1979 and 1980-1987

Cultural Group (level of integration)	*Age-Adjusted Rates 1957-1968*	*1969-1979*	*1980-1987*
Apache (low)	41.3	59.8	48.8
Navajo (medium)	10.2	20.4	18.2
Pueblo (high)	24.0	44.8	32.0
U.S.	12.1[2]	12.2[3]	11.6[4]

[1] Age-adjusted rates based on U.S. 1940 standard population.
[2] Age-adjusted rate for 1963.
[3] Age-adjusted rate for 1974.
[4] Age-adjusted rate for 1984.

American Indian tribes in the Southwest since the late 1950s, but more so on some than others (Van Winkle and May, 1986). The Southwestern data, as illustrated below, show the importance of using both traditional modes of integration and integration changes brought about by acculturation as they affect Indian groups.

Moving to Table 2, the suicide rates of various tribal groups and communities *within* cultural types also show variation. Table 2 illustrates the variation in suicide rates for the eight largest Pueblo tribes. This variation is introduced by the other aspect of social integration mentioned above, change resulting from modernization and acculturation. Pueblos with the highest suicide rates tend to be those who have undergone high levels of change from modernization and acculturation, who are closest to urban areas, and/or who have been less able to shield, buffer, filter, counter, or otherwise stabilize their culture from the introduction of modern, western culture. Within both the Pueblo tribes and the various Navajo communities there is variation in suicide and deviance rates. Generally implicated in the higher rates are greater levels of social change and recent acculturation (Van Winkle and May, 1986, 1993). Among the Apaches, social change and acculturation are very influential as well, but the wide fluctuations in rates is less easily and clearly related to the social integration forces because of their much smaller population size.

Therefore, a single statement that suicide varies inversely with the degree of *traditional tribal social integration* does not hold true in detailed, longitudinal comparisons in the Southwest. With American Indians the correct statement is that *suicide varies inversely with the degree of integration in a tribal group as influenced by both traditional cultural practices and by acculturation and change resulting from modernization.* Thus, the translation of Durkheim's

Crude Suicide Rates (per 100,000) and Level of Acculturation for Pueblo Tribes in New Mexico with Populations over 1000 for 1954-1962, 1957-1965, 1966-1972, 1973-1979, 1980-1987, and 1957-1987

Tribe	1954-1962[1]	1957-1965[2]	1966-1972[3]	1973-1979[3]	1980-1987[4]	Overall Level of Acculturation[5]
Laguna	16.9	27.7	60.5	55.7	56.2	48.6 Acculturated
Isleta	22.2	24.0	57.6	44.8	32.7	38.4 Acculturated
Taos	16.7	19.0	37.8	52.0	10.2	29.0 Transitional
Zuni	2.8	5.6	30.3	53.7	38.4	33.7 Transitional
San Felipe	0.0	0.0	48.1	19.3	12.5	18.1 Traditional
Acoma	5.0	5.5	6.9	33.3	29.2	19.7 Traditional
Jemez	8.3	18.5	11.7	9.2	22.6	16.1 Traditional
Santo Domingo	6.5	0.0	0.0	6.7	10.1	4.9 Traditional

[1] Rates taken from Levy (1965).
[2] Classification originally from Levy; minor adaptations from Van Winkle and May (1993).
[3] Rates originally published in Van Winkle and May (1986).
[4] Rates also found in Van Winkle and May (1993).

ideas to American Indians may have been simplified by both the scholars who have written only of social disorganization and those who have emphasized the singular effect of the traditional culture.

Other Indian Studies with Suicide Rates

The fallout or adverse effect of rapid social change and acculturation on a number of individuals has been documented in other native communities elsewhere in North America. A variety of conditions, from alcohol abuse to all forms of violence, are increased in rate by acculturation in its earliest stages. Many times, all of these social pathologies are manifested simultaneously in one community because of major disruptions and/or dislocations (Shkilnyk, 1985), but also because of more gradual and creeping changes (Braroe, 1973; Bachman, 1992). But the bulk of the literature which implicates rapid social change and acculturation as problematic among Indians and Alaska Natives uses suicide as the dependent variable.

Table 3 presents a summary of a number of North American suicide studies among Indians. These works provide further evidence of the importance of social integration. In the table cultural group/tribal studies are aggregated by the level of traditional social integration of the group studied—low, medium, or high. Therefore, the table only considers one of the two elements of integration mentioned before. For this reason, and possibly others, there is variation within each grouping. For example, the range in rates among the low-integration tribes is from 13 to 267 per 100,000. Similarly, high-integration group rates range from 0 to 74.

The average (mean) suicide rates for the three groupings form a basis for further interpretation. The mean ($\bar{x}$) rates for low-, medium-, and high-integration groups produce the exact sequence that Durkheim would have predicted. The rates of suicide per 100,000 are inverse to the level of integration: low social integration = 56.9, medium social integration 31.9 (41.5 excluding the Navajo),[5] and high social integration = 28.3. Furthermore, the standard deviations are higher in the low-integration tribal study results which is also consistent with Durkheim's theories. Lower integration societies allow more variation in human behavior in general and suicide in particular.

A similar pattern emerges when the median suicide rates are compared across tribes. The inverse relationship still holds for suicide and level of integration, but the magnitude of difference between levels is less: high-integration tribes = 18.5, medium = 30.0, and low-integration = 45.0.

A caution in over-interpreting this summary of other studies is necessary. Because these studies were undertaken at different times, there are unaccounted variations in social conditions covered, and various research methods were employed over time. This may be an alternate explanation of the variation in rates. Furthermore, academic studies of suicide, both published and unpublished, are seldom undertaken and pursued to completion in groups which

[5] Rates also found in Van Winkle and May (1993).

Table 3.

Suicide Rates of Various Indian Tribes and Alaska Natives from Selected Studies, 1950s-1980s

Geographic or Cultural Type (Tribe/Group)	*Level of Traditional Integration*	*(Time)*	*Rate (per 100,000)*	*Source*
1. Plains (Shoshone - Arapaho)	Low	1980s	50	Bechtold, 1988
2. Yukon Indians (all)	Low	1959-64	38	Butler, 1965
3. Basin-Plateau (Shoshone)	Low	1972-76	90 (epidemic year=238)	Berman, 1979
4. Alaska Natives (all)	Low	1970	29	Blackwood,1978
5. Plains (Sioux)	Low	1981-83	66	Claymore, 1988
6. Plateau (Shoshone-Bannock)	Low	1963-69	98	Dizmang et al., 1974
7. Alaska Natives (all)	Low	1978-85	1978-32; 1979-36; 1980-45; 1981-45; 1982-37; 1983-43; 1984-35; 1985-69	Forbes & Van der Hyde, 1988
8. Manitoba Indians (all)	Low to Medium	1973-82	40	Garro, 1988
9. Alaska Natives (all)	Low	1961-65 1966-70	13 25	Kraus, 1974
10. S.W. Plains (Apache)	Low	1965-67	20	Levy & Kunitz, 1969
11. Plains (Sioux)	Low	1971-73	73	May, 1973
12. Northern Manitoba Indians (all)	Low to Medium	1981-84	77	Ross & Davis, 1986
13. Canadian Natives (Indian and Inuit)	Low to Medium	1977	41	Seyer, 1979
14. Plains-Woodlands (Ojibway)	Low	1975-82	62	Spaulding, 1985-86
15. Plains (Shoshone-Arapaho)	Low	1985	230 (epidemic period)	Tower, 1989
16. Woodlands	Low	1971-74	23	Fox et al., 1984

Table 3. cond.

Geographic or Cultural Type (Tribe/Group)	*Level of Traditional Integration*	*(Time)*	*Rate (per 100,000)*	*Source*
1. Desert Culture (Papago)	Medium	1969-71	30	Conrad & Kahn, 1974
2. Northwest Coast & & Plateau (various tribes)	Medium	1968	39	Cutler & Morrison, 1971
3. Navajo	Medium	1954-63	8	Levy, 1965
4. Desert Culture (Anonymous)	Medium	1968-70	58	Miller, 1979
5. Northwest Coast & Plateau (various tribes)	Medium	1968-77	30	Nat'l. Native Alcohol Abuse Program, n.d.
6. Northwest Coast	Medium	1969	28 **Annual average rate = 31.9 (SD = 19.2, n=35) median = 30.0 excluding Navajo mean=41.3 (SD =13.9, n = 25), medium =30.0**	Shore, 1972
Pueblo (Various)	High	1960-62 1963-65 1966-68	45 46 74	Biernoff, 1969
Woodlands	High	1972-73	12 (Cherokee) 8 (Lumbee)	Humphrey & Kupferer, 1982
(Lumbee & Cherokee)	High	1974-76	31 (Cherokee) 10 (Lumbee)	
Pueblo (Hopi)	High	1956-65 1961-70 1966-75 1971-79	12 28 29 39	Levy & Kunitz, 1987
Woodlands (Cherokee)	High	1982-82 1981-82	0 **Annual average rate = 28.3 (SD = 16.3, n = 60), median = 28.5**	Thurman et al., 1985

have low rates. Therefore, there are in all probability more studies on the low-integration/high-rate groups than among the others. Lastly, many of the studies in Table 3 are isolated tribal studies. Even compiled in aggregate form as they are here, or in a complete bibliography (May, 1990), they may not be as representative of the actual or true prevalence as are studies of all tribes of different cultures in a geographic region. They represent a selective and possibly biased view of time prevalence. Regional studies of a number of tribes using the same methodologies are more desirable (e.g., Seyer, 1979; Shore, 1972; Van Winkle and May, 1986). Nevertheless, with the above caveats, this review of other studies provides some general and interesting validation of Durkheim's theory of social integration and suicide, and a corroboration of Indian suicide patterns detailed in the Southwestern studies.

OTHER DURKHEIMIAN ISSUES IN SUICIDE AMONG INDIANS

Marriage and Age

In addition to the utility of Durkheim's major thesis for describing the variation of suicide rates of tribal groups, other aspects of his synthesis apply to American Indians. Durkheim suggested that "married persons of both sexes enjoy a coefficient of preservation in comparison with unmarried persons" (Durkheim, 1951, p. 179). As seen in Table 4, the majority of the decedents from the three cultural groups in New Mexico were not married. The Navajo and Pueblo data suggest that being married may be more protective in recent times than was true in the past—or the data might suggest that marriage is occurring later or is less common. But there is a substantial difference between United States and New Mexico Indian patterns in this regard, which is partially evident in Table 4. The vast majority of New Mexico Indian suicide victims in the 1980s has never been married (63 to 71 percent); only 37 to 29 percent have been married. In the general United States population, over twice as many people have been married (72 percent). Those who have been divorced (16.2 percent), separated (9.2 percent), or widowed are a substantial segment of the ever married United States population, far greater than the Indian-only data.

Age and Suicide

Age is an important factor in both Indian suicide and in shaping marital statistics of Indian suicide victims. In Table 4 the average age of suicide is presented. The young age at suicidal death among New Mexico's Indians is evidenced by a median of 24 to 26.5 years compared with 41.6 years for the United States. This is a very typical feature of Indian suicide in virtually all studies (May, 1990). Indians and Alaska Natives commit suicide at a much younger age. Therefore, the significance of youthful suicide is twofold. First,

Table 4.

Marital Status and Age at Suicidal Death for the Apache, Navajo & Pueblo Indians in New Mexico for 1957-1968, 1969-1979 & 1980-1987

	1957-1968	*1969-1979*	*1980-1987*
APACHE			
Married	36.4	11.8	37.5
Not Married	63.6	88.2	62.5
Mean Age at Death	26.0	23.8	26.0
Median Age at Death	23.0	20.0	25.0
NAVAJO			
Married	63.6	44.6	33.3
Not Married	36.4	55.4	66.7
Mean Age at Death	30.6	31.4	30.1
Median Age at Death	26.0	29.0	26.5
PUEBLO			
Married	50.0	32.6	28.8
Not Married	50.0	67.4	71.2
Mean Age at Death	30.5	27.4	26.0
Median Age at Death	28.0	24.0	24.0
U.S. GENERAL POPULATION[1]			
Ever Married	-[2]	-	71.7
Not Married	-	-	28.3
(Divorced)	-	-	(16.2)
(Widowed)	-	-	(9.2)
Mean Age at Death	-	-	41.4
Median Age at Death	-	-	41.6

[1] Source: National Center for Health Statistics. *Vital Statistics of the U.S., 1983, Vol. II. Mortality, Part A.* Washington, DC: U.S. Government Printing Office.
[2] Data not available.

some of the lack of marriage in Indian suicide victims is explained by their young age at suicide. Many have not yet reached an age where the probability of marriage (or divorce, separation, or widowhood) is great. Second, the late teens and early twenties is a period of high stress and low attachment to stable, adult groups (either traditional tribal or modern western) which promote high integration to social systems. The choices of future roles and the lack of integrative forces to carry an individual to social stability and success in a normatively approved, secure, and supportive role present special challenges for youth in most societies today. But they appear to be even greater stressors for young American Indians (May, 1987; Manson, et al., 1988; Lin, 1987; Levy and Kunitz, 1987; LaFromboise and Bigfoot, 1988).

The elevated suicide rates of Indians aged 10 to 29 are consistently higher than those of the general population of the United States. For example, in New Mexico during the period 1957 to 1979 Indian suicide rates were 5.4 times higher than U.S. rates in ages 10 to 29 years, and 3.6 times higher for the same age cohorts in from 1980 to 1987 (Van Winkle and May, 1986; May and Van Winkle, 1993). When considering the specific rates for those under 30 years by 5-year age cohorts, Indian rates are higher in all cohorts. Therefore, the difficulty of acculturation to adult modern or traditional society is probably exacerbated by minority status. One might hypothesize that the marginal level of social integration among youth is probably amplified by the minority status of Indian youth and the challenge of two different sociocultural traditions (McFee, 1968; Bushnell, 1968). This, then, may also be an example or extension of social factors mentioned by Durkheim.

We do not care to or have space to venture into the subtypes of suicide which Durkheim described. But one aside should be noted here in the form of a question. Might it also be said that Indian youth are more likely to experience relatively higher rates of suicide due to fatalism or anomie than other youth groups in America (Breed, 1970; and Davenport and Davenport, 1987)?

Gender and Suicide

Durkheim does not directly address gender or sex except in relation to marital status. He states that marriage is less protective of suicide risk for women. In our American Indian suicide studies, more males who committed suicide were married than females. On face value alone this seems contradictory to Durkheim's work, but it is not. Roles in society are based on gender to a very great degree. Social role is a major influence on suicide among most American Indian tribes.

American Indian suicide is predominantly a male phenomenon. Among all three cultural groups of Indians in New Mexico, the male-to-female ratio is much higher than in the United States general population.

This high rate of male dominance of completed suicide[6] has also been found in virtually all other tribal studies (Butler, 1965; Havighurst, 1972; Garro, 1988; Forbes and Van Der Hyde, 1988; Trott, et al., 1981). Therein lies the relevance to Durkheim's work. The explanatory theme generally put forth in the literature cites an erosion in male roles in traditional tribal culture (Dizmang, 1967; Wills, 1969; Barter and Weist, 1973; Travis, 1984). Indian males are viewed as being less well integrated into overall United States society than Indian women whose roles have changed less in recent decades. The warrior, farmer, hunter, and protector role of the male is no longer as viable in traditional or modern Indian societies, while the childbearer and home-maker role of the female has changed less. Further, Indian females are more likely than males to enter the modern wage work labor system in education, clerical, administrative, social service, and other service sector jobs, jobs which are quite dominant on and around most Indian reservations in the West (Kunitz, 1977; Travis, 1984). Thus, the changing male role and its minimally integrating properties may well predispose a higher number of Indian males to suicide, particularly at a young age when adjustments are being made to life, occupation, and adult male identity.

Methods for Suicide

Durkheim said that "each people has its favorite sort of death" (Durkheim, 1951, p. 290). American Indians in the Southwest tend to use more violent means than others in the United States. Hanging and firearms combined to account for 86 to 100 percent of all Indian deaths compared to 65 to 74 percent in the general United States population.

Furthermore, studies of other forms of mortality indicate that additional means of violent death (parasuicide) are of high prevalence among most tribal groups. Deaths from motor vehicle crashes, homicide, and the overuse of alcohol (both chronic, and most particularly, acute) are quite high (May, 1989a, 1989b). For example, among one tribe, the Navajo, the age-adjusted death rates from motor vehicle crashes, other external injuries, alcoholism (cirrhosis of the liver, alcohol dependence syndrome, and alcoholic psychosis), and homicide were 7.1, 3.4, 21.3 and 2.3 times higher in 1975-77 (Broudy and May, 1983). They have also remained relatively high through the 1980s (Howard, 1990). These patterns are common, and in some cases even higher, among other Indian groups as well (Office of Technology Assessment, 1986).

Methods of suicide among various tribes change with suggestibility, imitation, and fad as Durkheim suggested. On many reservations suicides cluster by time (Ward and Fox, 1977; Fox, et al., 1984; Bechtold, 1988; Tower, 1989) and by method. For example, it is not uncommon for epidemics to occur in a particular season or year as illustrated by several rates in Table 3. Furthermore, methods change by fad. Suicide by hanging when in jail has been popular at various times among Plateau and Plains Indian tribes such as the Shoshone (Dizmang, et al., 1974) and the Sioux (May, 1973). Suicide by rifle shot has been the most common method in the Southwestern tribes over most years (Shuck, et al., 1980; Van Winkle and May, 1986; May and Van Winkle, 1993), although recent trends indicate a substantial increase in suicides by hanging. Popular media (as in Phillips, 1974) and international trends can also influence method choices among Indians as they do other ethnic groups. During the Vietnam War there were a number of reports of suicide by self-immolation on Indian reservations. These were very suggestive of the pattern practiced by Buddhist monks in Southeast Asia frequently portrayed in the media at that time.

Suicide and Homicide

In some American Indian groups, suicide and homicide coexist, a fact which would not surprise Durkheim (1951, pp. 354-360). Some low-integration tribes, such as Plains culture tribes, have consistently high rates of both suicide and homicide. Furthermore, homicide and other violent deaths might also be viewed by Durkheim as expressions of social forces similar to suicide. Durkheim made a case for the common etiology of violence, as have many scholars since (Henry and Short, 1954, 1957; Tabachnick, 1973; Stull, 1973, 1977).

Social Integration, the Family and Suicide

The major translator of social integration to the individual is the family. Durkheim called this concept the family society or conjugal society. He specifically referred to disruption in the family as "domestic anomie" (Durkheim, 1951, pp. 259-276). Disruptions in the social ties through death, divorce, family density (very high birth rates), and other events do not reflect tranquility in marriage.

In addition to the marital status and age influences mentioned previously, a number of Indian studies have implicated the quality of family integration as a factor in suicide. Dizmang and his co-workers (1974), in a controlled study of Shoshone-Bannock adolescent suicides, found three key family problems to be explanatory of suicidal behavior. Families which produced suicidal youth were characterized by more desertion and divorce, the switching of children from one caretaker to the next for long periods of time, and high arrest rates of the primary caretakers. Berlin's (1985, 1986, 1987) writings corroborate the above findings as key etiological variables in suicide. So do the case-control studies of Fox and Ward (1977; Ward and Fox, 1977) among the Ottawa in Ontario, Canada. Furthermore, lack of family integration (familial disruption) has also been linked to child abuse and neglect among Southwestern Indians (Lujan, et al., 1989; DeBruyn, et al., 1992). Much higher rates of violent death, alcohol abuse, and suicide were found in several generations of Indian females who had abused and neglected their children.

Therefore, family disruption as a symptom of poor social integration is a key factor in suicide and other problems among Indians. Durkheim's analysis pointed the way in this area as well.

DISCUSSION

Durkheim's seminal work on suicide has been invaluable in our work among American Indians. This is particularly true of the guiding theory of social integration. How persons, whether Indian or non-Indian, relate to their own social groups is vitally important in all cultures. Furthermore, in behavioral science research, determining the social integration levels of a community or tribe will allow one to roughly estimate the level of suicide (and to some degree parasuicidal behaviors) which one can expect in a community. Two personal experiences of the senior author (P.M.) can illustrate the utility of this approach.

The Suicide of Joe Smith

Years ago when I was early in my career and employed as a commissioned officer in the United States Public Health Service, I was sent to a small, predominantly non-Indian town in the plains of western Nebraska which bordered a large Lakota (also referred to as Sioux) reservation in South Dakota. I was assigned to investigate the recent suicides of several Lakota individuals in the local jail each of which occurred independently over a period of a year. Collecting data on the age, sex, occupation, family status, religion, and statistical variables of the victims, and examining the physical layout and conditions of the jail consumed most of the morning. In the afternoon, while I was completing the data collection and some aggregate information at a desk in the jail office, the non-Indian sheriff approached me in a quizzical manner. He said to me: "I can understand why some of these Indians would kill themselves, for they have very little to live for. However, I can't understand why Joe Smith [fictitious name of local Caucasian] who lived here in town killed himself last week." I then proceeded to have an enlightening conversation with the sheriff, a conversation which proved to be both insightful and entertaining for both of us. I proceeded to ask a whole series of questions, but disguised them as statements about the social situation and social integration of Joe Smith. In other words, I used the statements as vehicles for questioning the sheriff.

I said, "I think that Joe was in trouble financially, for he had recently lost his job."

The sheriff said, "Yes."

"Joe recently got separated or divorced from his wife, didn't he?"

The sheriff said, "Yes."

"Joe was a member of [a Protestant church that I had seen upon entering town], yet he didn't go to church too regularly."

The sheriff said, "You are right."

Continuing on I made other probability statements, and in doing so I asked a whole series of specific questions about Joe's commitment to his occupation, his drinking, children, club affiliations, etc. I even guessed at Joe's age being 44 and only missed it by a year or two. The sheriff was amazed.

Finally after this conversation had gone on for quite a while the sheriff asked me, "You knew Joe, didn't you?" (At that time I lived and worked in a South Dakota town less than 100 miles away.) "You are putting me on," he said.

"No," I explained very humbly, "I just know of hundreds of Joes from the literature."

I then went on to explain the concept of social integration and how it affects virtually every social status and behavior that were the objects of my statements or questions. I also told him about several specific studies which augmented Durkheim's theories in ways that further helped me guess at Joe's presuicidal social situation.

That was in 1971. It was my first major experience that truly convinced me of the utility of Durkheim's theories, particularly as enhanced by the more contemporary literature. Previous discussions with police detectives and public health officials in Washington, D.C., while researching a master's thesis (May, 1970), had merely heightened my curiosity. This discussion and several subsequent ones during field work in the western portion of the United States really began to demonstrate to me the validity and utility of Durkheimian analysis.

Consulting on Suicide Problems

A second example should also be mentioned. The senior author is often asked to consult with various tribes and reservation groups on alcohol abuse, suicide; motor vehicle crashes, fetal alcohol syndrome, and other social problems. Before going to any western reservation or bordertown community, it is quite possible to predict or at least to anticipate a general range of self-destructive behavior which one can expect to find there. Even without exposure to any of the rates of the particular mortality, morbidity, and other problem behaviors for a reservation, knowing the social integration of the traditional tribal culture and the modernization forces which are at play there, one can anticipate what will be found. For example, if going to a Northern Plains reservation characterized by low integration and high social pressure of modernization, I might anticipate that: (1) the suicide rate will be 4 to 10 times the national average (even higher in certain short time clusters), (2) suicide will be predominantly among youth, (3) methods usually will be violent or severe, (4) alcohol involvement generally will relate to binge and flamboyant drinking patterns, (5) problems of self-destruction will be predominantly among the males and among a limited group of multi-problem families, and (6) individual suicide victims will be characterized by marginal levels of social integration regardless of the specific pattern or cultural theme.

Some other dynamics of suicide, however, are less easily discerned because of local fads, cultural trends, or physical conditions. For example, the exact method of suicide or attempt (i.e., caliber of gun, or exact type of drug used to overdose), the place of suicide, the intensity of clusters, and the immediate or crisis-like precursors will frequently vary from one tribe to the next. As some have written, there is a general degree of susceptibility to self-destruction which exists or is generated within a community (Davis and Hardy, 1986). But specific, temporal, and localized influences will then shape the actual manifestation or specific outcome characteristics. Durkheim's work, however, provides the general framework which helps in understanding the magnitude of the problem that is actually manifested, as well as some of the recurring patterns found in the personal variables. Knowing the general patterns which emanate from social structural forces, allows one to concentrate on the localized specifics of the suicide problem.

Other Behavioral Health Problems

Using similar guidelines when working with behavioral health problems other than suicide, one can further utilize Durkheim's social integration concepts as useful guides. For example, the rate of fetal alcohol syndrome (FAS) and rates of maternal drinking will vary greatly and rather predictably from a low-integration tribe to a high-integration tribe (May, et al., 1983; May, 1991). Low-integration tribes have a higher prevalence of maternal drinking (than do other tribes) which is characterized by rather heavy, sporadic, binge drinking. High-integration tribes have a very low prevalence of women who drink at all, but through ostracism and other forces of social isolation, a pattern of persistent, chronic, and heavy drinking is common among those few who do drink. Thus, variations in social integration produce unique, yet predictable patterns and rates of FAS among the various groups. The FAS rates in the low-integration tribes are generally five to seven times higher than high-integration groups in most time periods studied among Southwestern tribes (May, et al., 1983). Similar patterns seem to hold outside the Southwest as well (May, 1991).

Fetal alcohol syndrome, then, like suicide, is inversely related to social integration. Social integration exerts influence on female drinking behaviors, and consequently on FAS.

Therefore, from Durkheim's theories and the scholarly work of others, a useful and practical understanding emerges. Applied solutions can ultimately be planned for a variety of public health problems. Adult alcohol abuse, motor vehicle crashes, and a number of behavioral health problems other than suicide can all be approached, analyzed, understood, and interventions planned through the use of Durkheimian methods (May, 1986, 1987, 1989a, 1989b, 1992).

CONCLUSION

Durkheimian theory and knowledge, used carefully and sensitively, will many times prompt people from other disciplines or academic training to take note. The utility and ability of Durkheim's general theory and his specific concepts have proven to be valuable tools for predicting specific phenomena in many settings. The general applicability and accurate nature of Durkheim's theories

have laid the groundwork for insight which is substantial and many view as impressive in application. When combined with other more recent and complementary literature specific to American Indians, Durkheim's work is extremely useful in applied situations. One must, however, be careful not to overstep one's bounds or assume too much in such situations. Furthermore, the risk of committing the ecological correlation fallacy (Robinson, 1951) is always present. But a knowledge of Durkheim's theory and methodological approach can assure that one will seldom be taken completely by surprise when dealing with suicide or related issues.

Such is the nature of Durkheim's suicide theory. With careful research and elaboration, one can arrive at a broad understanding of the social forces which influence individuals in suicide and in a variety of related behaviors. Many of these behaviors, while seeming to be quite unique, individual, and isolated, are heavily influenced by common and rather universal social and cultural forces. Disciplines which dwell primarily on the individual often miss these broad and very useful insights. Disciplines which deal with the level of the organ, tissue, or cell may never know the joy of the insights which Durkheim discovered and delivered one hundred years ago.

To us, then, Durkheim's *Suicide* and his theory have been amazing tools. In our opinion, *Suicide* is the first major theoretical work in sociology which is of prime applied importance. We continue to use it in our work, and are thankful for it.

NOTES

1. In suicide studies among American Indians and Alaska Natives religion has not been explicitly studied to any degree, nor is it presented in this chapter due to the nature of our data, vital statistics. It is, however, a key variable in understanding suicide among both aggregates and individuals. For this reason our text mentions it as an important topic where appropriate.
2. Modernization is a process of conforming to present-day practices as expressed in mainstream culture and media. Modernization is not by definition a negative force for individuals and cultures, but among Indian tribes it frequently elevates rates of personal tragedy such as suicide.
3. Some of this fluctuation is caused by the small number (<7000) of Apaches in New Mexico.
4. Acculturation refers to the process of cultural change in which contact between two or more distinct groups results in the mixing of elements of the two groups. Usually one group takes on elements of the other group's culture to a greater degree than the other (Gould and Kolb, 1964; see also Linton, 1972; Walker, 1972). Acculturation of Indians to mainstream United States society has been increased or sped up by modernization. The building of new roads, more access to motor vehicles, and the saturation of tribes with new and abundant forms of media (television, radio, movies, videos, and print) have all accelerated change, typically acculturation, of Indians to the mainstream.
5. Many social scientists and others have continually treated the Navajo as a special group, characterizing them as highly unique from most other tribes and somewhat less negatively affected by the forces of modernization, change, and acculturation than other tribes (Kluckholn and Leighton, 1962; Dutton, 1983). They are the largest tribe in the United States (220,000 members), they are mostly united on one massive reservation in the Southwest, they have been protected from mainstream social intrusion to a much greater degree than other tribes, and they have proven to be very highly adaptable to change over the past centuries. In a sense their minority status has been different. Therefore, they may not be as subject to, nor as likely to conform to, the same social phenomena that affect other tribes, particularly other medium integration groups.
6. Attempted suicide is predominantly a female behavior among Indians as among other groups (May, 1987, 1973).

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SUICIDE AND SELF-DESTRUCTION AMONG AMERICAN INDIAN YOUTHS[1]

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ABSTRACT. Suicide mortality among most tribes of American Indians has predominantly been a problem of the young. With the recent concern about teenage and youthful suicide in the general U.S. population, it is important to re-examine youthful suicide among Indians and to compare the Indian experience with that of the U.S. Using a variety of data sets, sources, and studies, this paper presents a brief overview of the nature of our knowledge of youth suicide, suicide attempts, and single vehicle crashes among various tribes. Included in the presentation is a brief history of the professional and governmental concern about suicide among Indians and a twenty year follow-up of suicide death at an Intermountain Indian reservation. The variety of prevention and intervention efforts undertaken at this particular reservation are described as positive examples which other communities and/or tribes might follow. Mental health professionals must continue to learn from the experience of tribes and communities who have suffered in the past from epidemics of self-destruction so that the future is more positive.

Of great concern to all U.S. professionals in mental health and education fields is the fact that youth suicide rates have risen dramatically over the past three decades. During this era, the suicide rate among those aged 15-24 years tripled, going from 4.5 per 100,000 in 1958 to 12.1 in 1982 (U.S. Vital Statistics, 1967; National Institute of Mental Health, 1985). The numerical increase in this period was from 1000 to over 5000 deaths each year. A substantial increase has also been registered in suicide among youth aged 10-14 years, but rates in this age group might be more subject to changing definitions of the classification of suicide mortality than to an actual change in behavior.

The increase in youth suicide is greatest among males, particularly white males, who in 1982 had a rate twice as high as black males in the ages 15 to 24 years (See Table I). White females aged 15-24 have rates of suicidal death which are only one-fourth that of white males, and black females have a rate which is one-fifth that of black males and one tenth that of white males (NIMH, 1985). Therefore, from readily available data published by vital statistics on the two major color/ethnic groups in the U.S., the problem is greatest among whites, particularly males.

The focus of this paper is a brief review of selected studies and data on suicide and self-destruction among American Indians of various tribes. While the above data summarize the trends among the largest categories of U.S. youth, this paper will define the nature and trends of suicide among this na-

tion's original ethnic groups, particular tribes of American Indians, all of whom are now a vastly outnumbered minority.

TABLE I
SUICIDE RATES* IN THE UNITED STATES BY COLOR AND GENDER FOR AGES 15-24, 1982

Group	Rate
White males	21.2
Black males	11.0
White females	4.5
Black females	2.2

*Rates per 100,000

General Characteristics of the Indian Population

Currently in the United States there are over 300 different tribes recognized by the federal government. The Indian and Alaska Native population numbered 1.4 million in the 1980 census. Indians therefore are 0.6% of the U.S. population. Of this population, more Indians now live off reservations and away from Native communities (63%) than live on one of the 278 reservations and 209 Alaska Native villages (See Figure I). Thus the Indian population is no longer predominantly in rural, reservation areas; but most still reside in the Western U.S. in areas and/or states close to their reservation. Since World War II Indians have become more urban and involved in mainstream American society (U.S. Bureau of Census, 1984a; 1984b). Nevertheless the average income for Indian families in the U.S. was considerably lower ($13,678) than the national average ($19,917) and twice as many Indians (27.5%) were below the poverty level. The unemployment rate for Indians continues to be higher than national averages (two times) and on some reservations unemployment is over 60% (U.S. Bureau of Census, 1984a, 1984b). The median age of Indians is much younger (22.9 years) than the general U.S. population (30.0 years) due mainly to higher fertility rates in past decades. Finally, the educational attainment of Indians is below national averages especially when measured by college experience (Brod & McQuiston, 1983). While 16% of those 25 years and older in the U.S. population have completed four years of college, only 8% of American Indians have done so (U.S. Bureau of Census, 1984b).

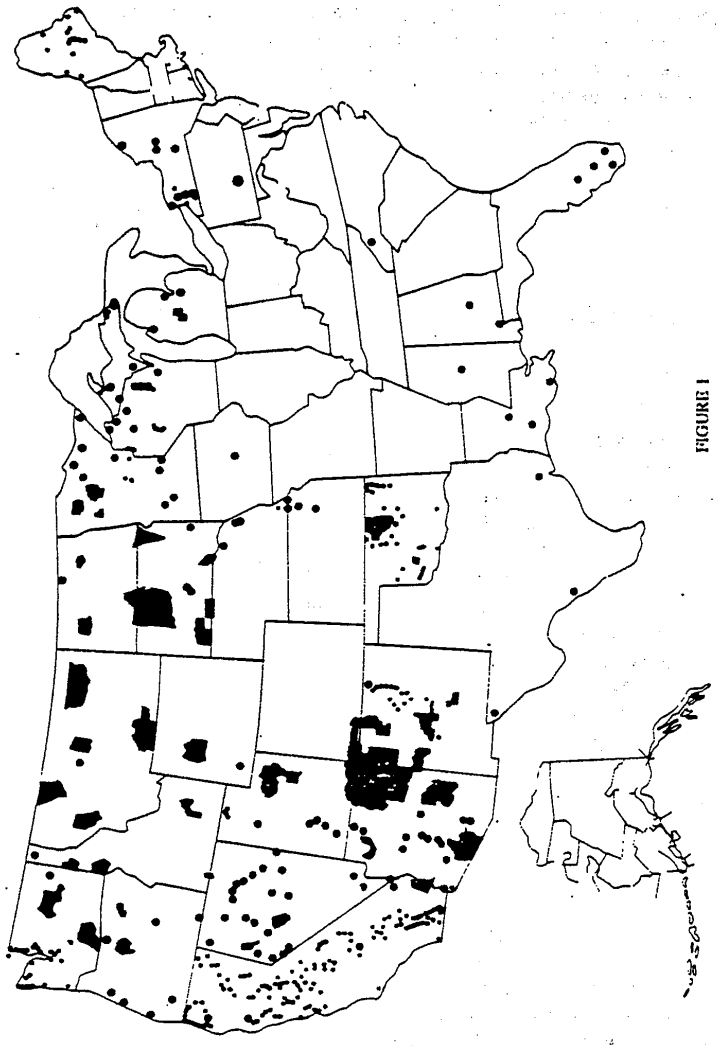

FIGURE 1
FEDERALLY RECOGNIZED INDIAN RESERVATIONS AND ALASKA NATIVE REGIONAL CORPORATIONS, 1985

Source: Native American Science Education Association, 1986

The above statistics are only general averages for a very diverse population. Realistically there is tremendous variation in social, economic, and educational factors from one tribe to the next, one reservation to the next and from community to community. In other words the Apache of New Mexico have very different lifeways from the Quinault of Washington; the experience on the Zuni Pueblo reservation is very different from that of Taos Pueblo in another part of New Mexico; and the social indicators and experiences of the Indians in Albuquerque, New Mexico are very different from those in Seattle, Washington or Rapid City, South Dakota. The cultural and socio-economic conditions vary tremendously as do the behaviors which result from these conditions. Some tribes and Indian communities are much better off than others, and one must be cautious in generalizing too broadly.

Background on Indian Suicide

Such is the case with Indian suicide. When the first broad, national and governmental attention was focused on Indian suicide, it was 1968. Robert F. Kennedy was head of the Senate Subcommittee on Indian Education and also seeking the Democratic Presidential nomination. On a campaign/fact finding visit to the Intermountain west, he attended a community meeting on a local Indian reservation. On that particular winter day, local concern was acutely focused on the recent suicide of an Indian youth in a local jail. Therefore, in Senator Kennedy's visit of the area, the suicidal death of this youth and the frequency of Indian youth suicide in general became major topics of discussion and concern. With this visit and subsequent events, major press coverage ensued and a number of national news stories were printed throughout the next few years on the "Indian suicide problem." Also following Senator Kennedy's visit, a great deal of the attention of the senate subcommittee became focused on self-destruction. Federal agency action was prompted by this attention and several agencies began to look into suicidal behavior at this Intermountain reservation.[2] The National Institute of Mental Health (NIMH) along with the Indian Health Service (IHS) and Volunteers in Service to America (VISTA) initiated pilot studies and efforts on the reservation. By the middle of 1968 preliminary research revealed a rate of suicide at the Intermountain reservation, 98.0 per 100,000 population, for 1960-1967 that was over nine times the national average (Dizmang, 1968). This rate received very wide distribution in the national press and it was often presented as the "Indian suicide rate" and not what it really was: the rate of this particular reservation for a limited period of time. Thus, this series of events spawned a new generalization about Indians, "The Suicidal Indian" stereotype. This stereotype was perpetuated for

many years in spite of the fact that some tribes, reservations, and Indian communities had, and continue to have, low and/or moderate rates of suicide. Time has also shown, as we will see in this article, that the high rate at the Intermountain reservation became even higher for awhile, but has declined considerably in recent years. Thus, Indian suicide, like other behaviors, varies tremendously from one location to the next and also over time.

General Characteristics Of Indian Suicide Today

The average suicide rate for U.S. Indians and Alaska Natives for the period 1980-82 was 19.4 per 100,000 which is 1.7 times the rate for the nation as a whole but lower than it was in the earlier 1970's. Looking at youths, the suicide rates for Indians and Alaska Natives aged 10-14, 15-19, and 20-24 were considerably higher. As seen in Table II, the rate for each of these categories is from 2.8 to 2.3 times as high as general U.S. rates. Therefore, the fact that Indian suicide is predominantly among the young is a first general truth. Conversely Indians in the older age groups have lower rates than the general population.

TABLE II
AGE SPECIFIC SUICIDE RATES* OF U.S. INDIANS AND ALASKA NATIVES (1980-82) AND THE U.S. GENERAL POPULATION (1981)

Ages	Indians and Alaska Natives	General U.S. Population	Ratio
10-14	1.4	0.5	2.8
15-19	20.8	8.7	2.4
20-24	36.4	15.6	2.3
All Ages**	19.4	11.5	1.7

Source: Indian Health Service, Office of Planning Evaluation and Legislation data.

*Rates per 100,000 population.
**Age Adjusted Rates to the Standard U.S. Population in 1940

Of the approximately forty studies published on suicide among various Indian groups, several other general characteristics emerge. A second truth is that Indian suicide in most tribes is predominantly male. Third, Indian women have particularly low rates of suicide in most tribes. Fourth, Indians generally use highly lethal or violent methods to commit suicide (guns and hanging), more so than other groups in the U.S. Fifth, tribes with loose social integration which emphasizes a high degree of individuality, generally have higher

suicide rates than those with tight integration (which emphasizes conformity). Sixth, tribes who are undergoing rapid change in their social and economic conditions have higher rates than those who are not (Levy, 1965; May & Dizmang, 1974; Shore, 1975; Webb & Willard, 1975; Willard, 1979).

We now need to turn to several, more specific studies to illustrate and expand upon the above generalities, particularly as they relate to the young people of various tribes.

Characteristics Of Youth Suicide Among Indians Of New Mexico

In New Mexico from 1957-1979, the suicide rate among Indians of all ages increased from 15.1 to 25.7 per 100,000, a 70% increase. In the United States during this period, the increase was 29%, from 9.8 to 12.6. Thus the New Mexico Indian rate increased more rapidly than the U.S., but actually no more rapidly than the overall New Mexico rate. As seen in Figure II, the New Mexico rate, although lower than the New Mexico Indian rate, increased 92% from 10.2 to 19.6. This pattern of vital events is common among Indian tribes. That is, the tribal patterns will in many cases mirror the patterns of the states in which they live, but the magnitude of the rates is different.

More important than the overall rate is the variation in the rates of different cultural groups in New Mexico. As seen in Figure III, the Apache, the Navajo and the Pueblo cultures[3] had very different rates from one another and rates which varied throughout the 23 year period. In general the more loosely or-

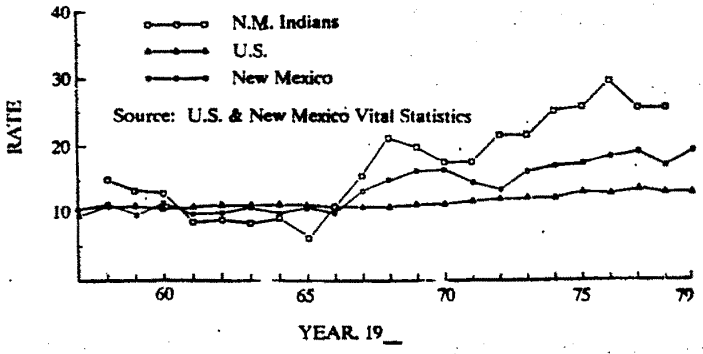

FIGURE II
SUICIDE RATES FOR NEW MEXICO, INDIANS AND THE U.S., 1957-79 (RATES PER 100,000.)

ganized tribes, the Apache, had the highest rates, while the Navajo and Pueblo, which are more tightly integrated, had lower rates. This variation is explained in detail by sociological and anthropological theories of social integration which have been applied to the study of Indian suicide by Levy (1965). The reader should note that the Navajo rate was considerably less than 10 per 100,000 throughout the sixties and early 1970's, which is a lower rate than the national average of the same period. This low rate may reflect the strong traditional organization of the Navajo during that time period. In all cases, however, the rates of all three cultural groups increased over the study period. The rate increases among all the tribes (the Apache and Pueblo in the late 60's and the Navajo in the early and middle 70's) corresponded to increased social contact with mainstream U.S. society. This contact was specifically in the form of wage work, improved transportation and communication and other social development (Van Winkle & May, 1986.) As will be elaborated later, this rapid social change is believed by many to have created increased levels of acculturation stress, anxiety and disruption among par-

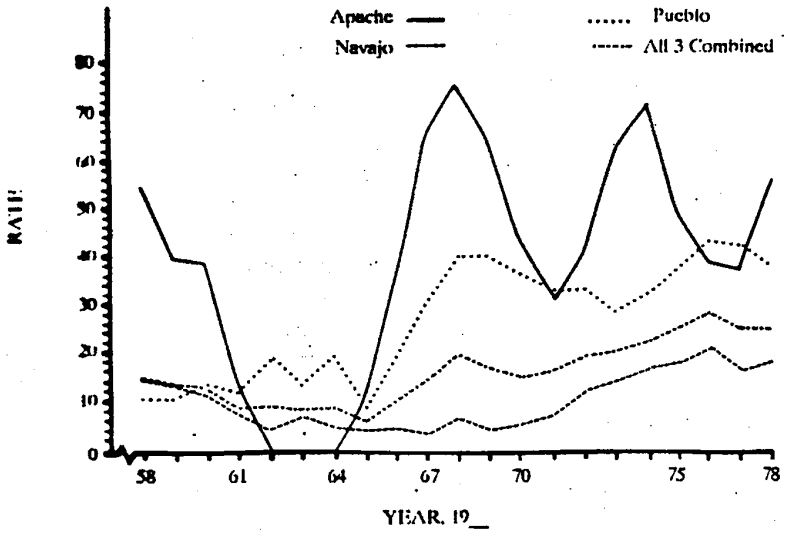

FIGURE III
THREE YEAR AVERAGE SUICIDE RATES BY AMERICAN INDIAN CULTURAL GROUPS IN NEW MEXICO, 1958-78

ticular families and individuals which then resulted in higher rates of suicide (Van Winkle & May, 1986).

Focusing more particularly on the youths of these tribes, Figure IV shows the rate of suicide for those aged 15-24 years. The ratio of New Mexico Indian rates to U.S. rates was 3.7 in 1957-65 and increased to 4.6 by 1973-79. Therefore the New Mexico Indian youth suicide rate was not only greater than the U.S. rate 20 years ago, but it has increased more rapidly than the comparable U.S. rate which has so alarmed health professionals.

An examination of tribal rates shows which tribes in New Mexico have suffered the worst from this increase. In Table III the data show the highest rates among the Apaches, the lowest among the Navajo and an inter-mediate rate among the Pueblo tribes. Unfortunately the young of all three tribes have experienced increases throughout the period.

To further the description of youthful Indian suicide in New Mexico, a summary of the demographic and structural variables is in order. Indian suicides under age 25 constitute a much greater percentage of all Indian suicides than youth suicide among others in the U.S. Among the U.S. general population in 1982, 18.5% of all suicides occurred before the age of 25 (NIMH, 1985), while among New Mexico Indians in the 1970's it was 45% (Van Winkle & May, 1986). Among the Apache the percentage was even higher, 60 percent. Indian youth suicides of all tribes in New Mexico are predominately male, 90% as opposed to 76% in the general U.S. population. Violent methods are more commonly used by New Mexico Indians than others in the U.S.: firearms 71%, hanging 22%, and overdose 2%. Most New Mexico Indian suicides occur in and around the home (67%) but rural areas and jails are also frequent locations. Virtually all who commit suicide were born locally (98% in New Mexico and Arizona), and the vast majority of all New Mexico Indian suicides lived (over 85%) in reservation communities. A similar percentage, 75%, of the suicides were committed on reservation. Most youthful suicide victims in New Mexico were single, students, or unemployed individuals, most of whom have not served in the military. Finally May was the most common month of suicide (12%), although there were a minimum of 6% in every month. At least 50% of all suicides occur on the three weekend days, Friday, Saturday, and Sunday (Van Winkle & May, 1986).

In the New Mexico study the Indian communities which had the highest rates of rapid change and acculturation stress generally had the highest rates of suicide, particularly among the youth. When the eight largest Pueblo tribes are classified by their degree of traditionalism (maintaining the old ways) versus their degree of acculturation, the acculturated tribes have the highest rates, the traditional have the lowest and the transitional (not highly traditional or

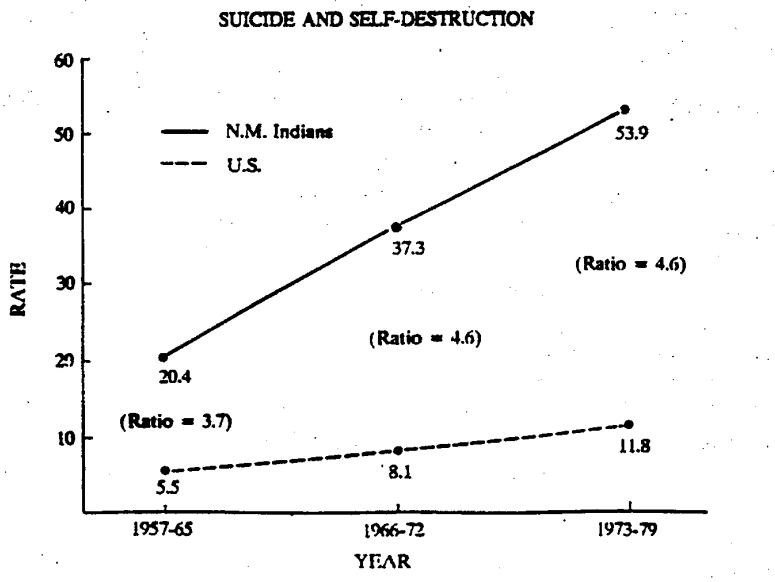

FIGURE IV
AVERAGE SUICIDE RATES FOR YOUTH AGES 15-24 FOR NEW MEXICO INDIANS AND U.S., 1957-79 (RATES PER 100,000)

TABLE III
AGE SPECIFIC SUICIDE RATES (PER 100,000) FOR APACHE, NAVAJO, AND PUEBLO INDIAN YOUTHS IN NEW MEXICO 1957-68 AND 1969-79 AND U.S. RATES 1963 AND 1974

	1957-1968				Mortality ratio		
Ages	Apache	Navajo	Pueblo	U.S. 1963	Apache to U.S.	Navajo to U.S.	Pueblo to U.S.
5-14	0.0	0.0	0.0	0.3	0.0	0.0	0.0
15-24	101.3	15.2	28.6	6.0	16.9	2.5	4.8

	1969-1979				Mortality ratio		
Ages	Apache	Navajo	Pueblo	U.S. 1974	Apache to U.S.	Navajo to U.S.	Pueblo to U.S.
5-14	9.5	0.6	3.4	0.5	19.0	1.2	6.8
15-24	166.8	15.2	29.9	91.7	10.9	2.7	8.4

Sources: U.S. data from U.S. Vital Statistics, Annual Reports 1963, 1974, Vol. I. Part A, Mortality. New Mexico data calculated from New Mexico Vital Statistics.

modern) have intermediate rates (Van Winkle & May, 1986). Since youth is a time of great uncertainty with difficult choices to make, Indian youth seem to be the most severely affected by acculturation stress.

Within individual tribes and communities, however, the degree of social integration and accultruation stress affects a limited number of families and individuals so severely that they eventually become self-destructive. When tribal communities are examined, the suicidal behavior is found to be limited to a small number of families. These families, unfortunately, are racked by a variety of problems such as high rates of divorce, desertion, arrest, and abuse of alcohol and ohter substances (Dizmang et al. 1974; Shore, 1975).

Further, when youthful suicides do occur in most Indian communities (most of which are very small) they generally tend to "cluster" together in time and space. That is, since suicide, particularly youthful suicide, is a "suggestible behavior" (Phillips, 1974; 1979), one suicide might trigger one or more additional ones among friends, relatives or others in the same locale who are in similarly unfortunate or hopeless circumstances. Recently (1985) one of these clusters of 9 suicides on a small reservation in Wyoming received considerable attention in national media. These types of "epidemics" in non-Indian communities in Texas, Colorado, Washington, and elsewhere have also been publicized, but the total magnitude (certainly in terms of rate and also in terms of the perspective of the small, minority community) of impact is greater in Indian communities.

Suicide Attempts

Another form of self destructive behavior of grave concern for Indian youth is suicide attempts. Unfortunately there are only a few studies on suicide attempts among any tribe (Shore, 1975; Conrad & Kahn, 1972). Table IV presents a summary of the key findings of two comprehensive studies from several reservations. A vast majority of all Indian suicide attempts, 66% in one study, are under age 25 and almost 50% are under 20 years old. Briefly, among the Indian tribes studied those who attempt suicide appear to be qualitatively and quantitatively different than those who complete suicide. Specifically there are far more people who attempt suicide (about 13 to each suicide) than who actually kill themselves. Most Indians who kill themselves are male while who attempt are female. The method of attempt is most commonly an overdose of medication while few deaths are by this means. In fact, in the Plains reservation attempt study, the amount of overdose was classified by pharmacists as serious in only 23% of the cases, mild to moderate in 39%, and non-toxic in 38% (May, et al., 1973). Indian attemptors are very young on the

average, 20.8 years, while suicides are in their upper 20's (May, et al., 1973; Van Winkle & May, 1986). Finally the Plains suicide attempt data indicate that the intent of many who attempt suicide was something other than death, and their actions were usually directed at altering an important interpersonal relationship (43%). Therefore, as in other non-Indian studies which compare suicides with those who attempt, Indian attemptors also appear to be less lethal and/or lower risk in motive and method than those who complete.

TABLE IV
A SUMMARY OF DATA ON AMERICAN INDIAN SUICIDE ATTEMPTS

	Plains Reservation*	Intermountain Tribe**	Northwest Tribes**
Suicides under 25 years old (%)	66		
Ratio of Completes to Attempts	1/13	1/9	1/17
Gender (% Female)	86	50	74
Alcohol/Substance related (%)	55	75	31
Location (%) - jail	2	26	0.5
- home	60	--	--
Method (% overdose)	84	50	50
Hospitalized (%)	42	44	44
No previous attempts (%)	60		
Cry for help made (%)	64		
Age of attemptors (median)	20.8		
Stated reason for attempt (%)			
argument with significant other	43		
to die	18		
Therapist's evaluation of reason (%)			
to change an interpersonal relationship	45		
to escape or flee a situation	27		

Source: *May, et al., 1973
**Shore, 1975

An important factor for therapists to remember when working with Indians who have attempted suicide, is the extenuating nature of the minority status and the unique and sometimes less advantageous social conditions generally faced by the patient. An Indian and his/her family may have been subjected to greater levels of social stress and disruption which may have left fewer resources to draw upon in therapy. Therefore, key therapy goals such as dealing with depression, reestablishing strong bonds with significant others, adopting new coping skills, and gathering new resources for change might be more difficult to achieve in a tribal or familial setting where acculturation stress has already compromised the social, psychological, and economic resources. Unfortunately, it is common for most Indian attempts to have come from this type of family situation. However, if the therapist is creative and able to completely explore opportunities of both Western society and traditional Indian culture, the range of therapeutic intervention is great and challenging.

Motor Vehicle Accidents

In order to complete the discussion of self destruction of American Indian youths, one must briefly mention motor vehicle accidents. Accidental death from motor vehicle crashes is higher among most tribes than the general population of the U.S. The general Indian age-adjusted rate of death from accidents in 1981 was 136.3 per 100,000 which is 3.4 times the U.S. rate of 39.8. Over half of these accidental deaths are from motor vehicle crashes (Office of Technology Assessment, 1986).

The situation of the Navajo is fairly illustrative of many reservations. Among the Navajo, accidents have been the leading cause of death since the 1950's, causing 4 to 5 times as much death as among the general U.S. population. In 1975-77 the age-adjusted rate of motor vehicle accidents was 152.5 per 100,000 which was 7.1 times the U.S. rates (Broudy & May, 1983). Males are more likely to be killed in accidents than females. The question is how many accidents are self-destruction?

The existing social science literature which defines this topic has estimated that between 2 and 20% of all single vehicle crashes are of serious suicidal intent (Schmidt, et al. 1972, 1977; Tabachnick, 1973). But most of this literature states that the majority of single vehicle crashes are moderately self destructive in that the individual takes great risks in a "game playing" fashion and has an "insufficient concern for his own self-preservation" (Markush, et al., 1968).

There are very few studies on single vehicle crashes among Indians (Wills, 1969; May & Katz, 1981). On and around the Navajo reservation, fatal single vehicle crashes involving Indians were found to be a higher risk group for self-destruction than either Indian fatal multiple vehicle crashes or non-Indian fatal crashes. For example significant differences were found between Navajo single and multiple vehicle crashes in that single vehicle crashes will more likely have: drinking drivers, drivers with an invalid license, drivers with a younger mean age, and crashes not affected by the weather or time of day (May & Katz, 1981). When Navajo fatal, single vehicle crashes were compared with non-Indian fatal, single vehicle crashes, they were again found to be more likely to have: a higher percent of alcohol involvement, drivers with an invalid license, and younger drivers.

A study among the Sioux in South Dakota reported three psychological autopsies of male drivers in fatal crashes (Wills, 1969). In all three cases the drivers were undergoing major life changes and stress and had problems with impulse control, alcohol, interpersonal relations and work which were similar to those described as common in single vehicle crashes among other popula-

tions (Schmidt, et al., 1972; Shaffer, et al., 1974). Self destructive desires and communication of serious suicidal intent varied in the Sioux cases.

In sum, single vehicle crashes among Indian youths may hide some forms of self-destruction and/or suicide as they do other populations. Some scholars refer to this level of suicidal behavior as "para-suicide" in that the behavior might result in death, but the intent is more "fate tempting" than an overt suicide.

The Interrelationship of Self-Destructive Behavior

All of the above behaviors are forces of self-destruction which affect Indian youth. Their interrelationship, while not definitively detailed by research among Indians or other populations, can be depicted in a "set theory" diagram. In Figure V the interrelationships of these behaviors is drawn.

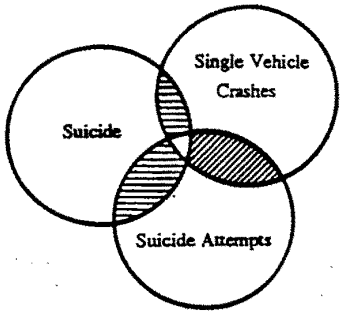

FIGURE V

HYPOTHETICAL RELATIONSHIP OF MAJOR SELF-DESTRUCTIVE BEHAVIOR

Suicide attempts and single vehicle crashes, while representing somewhat independent populations from suicide, overlap to a certain degree. That is, 20 to 40% of Indian suicide attemptors may be very similar in intent and motive to those who actually kill themselves. Similarly, those drivers in single vehicle crashes are also a relatively independent population of risk takers of which 2 to 20% may be highly suicidal and some additional percentage is also similar to suicide attemptors in lethality.

The unfortunate problem with these three behaviors, suicide, attempts, and motor vehicle accidents, is that many Indian communities have high rates of one or more, and some have high rates of all three. Therefore the challenge of prevention and intervention is great for many Indian groups. Far too many In-

dian youths are lost to accidents, suicide, and other traumatic deaths before they can assume a fulfilling adult role.

Problems, Prospects, and Solutions

This paper began with a discussion of youth suicide in general. If the relatively minor social and economic changes in U.S. society over the last 30 years have produced a tripling of youth suicide rates in mainstream society, then it may be no surprise that many Indian groups have also experienced increases. When most U.S. youths are faced with problems of adjustment, life meaning, and success in a fast-paced society with an economy of recession, Indian youths are faced with even greater challenges. Minority status, fewer economic and educational advantages, and cultural differences add to the difficulties of transition to adulthood (Berlin, 1986). Indian adolescents must choose from at least two, not totally clear paths, Indian and non-Indian. Those Indians who are the least likely to wind up as statistics in any major category of deviance are well grounded or well situated in both cultures (Ferguson, 1976; May, 1982). The question, then, becomes how to encourage and enhance such development in both the traditional Indian and the modern mainstream societies (Berlin, 1985).

Since the days when the first national attention was focused on suicide at the previously mentioned Intermountain reservation, tremendous strides have been taken by the tribe who resides there. While their success was not immediate, the current suicide rates are enormously improved. Table V presents the most recent suicide rates for the Intermountain reservation, Although the "epidemic" or high rates continued into the early 1970's, the more recent years were characterized by substantially lower rates. What was done at this reservation?

The Intermountain people whom I know are proud to discuss the progress they have accomplished. Briefly, they describe the situation of past, present, and future in these terms. When suicide was a problem in the 1960's and early 1970's, people felt as though a "black cloud" hung over the reservation and the two immediately adjoining boarder towns. Tribal identity and the self-esteem of many individuals were low. Social change and modernization were bringing new forces such as television, improved transportation, and new pressure to all tribal members to conform to new values and lifestyles, higher levels of formal education, and new expectations in wage work. The rapid change in values and expectations placed tremendous stress on families and individuals. Faced with such pressures many Intermountain families and individuals were able to cope, adjust, and succeed along fulfilling life paths.

But some who were challenged by these forces had weak family ties and inadequate social support systems (Dizmang, et al. 1974). With little support and faced with the specific consequences of prejudice and discrimination, a fractionalized (non-Indian) school system, and a world of unclear and seemingly hostile values, some were not able to cope. They then turned to various forms of retreatist behavior including self-destruction.

TABLE V
AVERAGE SUICIDE DEATH RATES (PER 100,000) AT AN INTERMOUNTAIN INDIAN RESERVATION 1972-84

Year	Rate
1972-76	173.14
1977-80	21.47
1981-84	45.43

Source: Data from Indian Health Service, Office of Program Statistics, Washington, D.C., 1987

As the suicide problem affected the outlook and welfare of the entire community, the tribe "claimed ownership" of the problem and set out to alleviate the problem through intervention and prevention at a number of levels. Through positive community action the tribal council endeavored to gain new resources, marshall existing resources (human, social, and cultural) and to apply them to overall community improvement. In fact, for a first intervention upon the specific suicide problem, a "holding facility" was established and staffed by tribal volunteers who would sit with, counsel and support youths considered "at risk" and in "crisis" for self-destruction. Since many of these crises were first brought to the attention of police, health, and community officials on and off the reservation, all were urged to cooperate. Later, grant and contract money was sought by the tribal council and the interventions were expanded to include a broader range of mental health and social services (Shore, et al., 1973). These services expanded the capability of the community to effect secondary and tertiary interventions on self-destruction by combining the strengths of both mental health professionals and the traditional healing practices which existed within tribal culture. Working in coordination with one another, a more competent mental health system has emerged which facilitates access to both medical services and traditional healing approaches. Second, the tribal council worked to develop new resources for all, particularly the youth, in the community. New housing funds were obtained for a num-

ber of new dwellings throughout the reservation. New recreational facilities such as a new gym, baseball fields, and festivals and rodeo grounds[4] were constructed. New relationships were negotiated with local school systems so that more Intermountain youth are now educated for a longer period of time on the reservation where they might benefit from a more positive cultural experience. Many new tribal businesses were created in the late seventies: a large, modern supermarket; a high inventory western store and traditional craft (beadwork, moccasins and other handmade items) sales outlet, tribal gas station, and restaurant. These enterprises have attracted the business of local non-Indians and also that of tourists on the major interstate highway which runs through part of the reservation. Third, tribal services (courts, social services, police, etc.) have continued to expand and improve over the years through both efficiency of organization and from being staffed by well educated tribal members. The tribal council and its departments are actively involved in a number of health and cultural promotion programs in the schools and other community institutions. Fourth, tribal advocacy and self-determination, which seemed quite rare in the 1960's, has improved. Advocacy in social, governmental, and legal matters has helped the tribe foster its best interests within areas such as protecting its land base, hunting rights, and other concerns. Just as the tribe's Bison herd, established in the late 1960's, has grown from less than a dozen animals to over 400 today, the Intermountain community development efforts have produced positive results.

Things are not perfect at Intermountain today, but no community in the U.S. can claim to be. Problems remain, but as evidenced by the lower suicide rate and other social indicators mentioned above, they certainly are not as manifest as before. As I have been told, the atmosphere at the Intermountain reservation is now more positive and the tribal self-image is good. The importance of tribal customs, community, and family are more generally recognized, acknowledged, and supported. There are now more positive examples, leaders, and role models for the youths to observe and emulate. As with any community today, the Intermountain reservation must continue to evaluate its needs, claim ownership, and advocate for solutions. As the past indicates, they may have done so with the devastating problem of youth suicide, and it appears to have paid more general dividends. Many communities, Indian and non-Indian, can learn from this example.

Notes

1. The author would like to thank Larry H. Dizmang, M.D., for giving me a start on this subject over seventeen years ago and Nancy Van Winkle for reviving my interest. Also I am appreciative of Carolyn Reese for asking me to prepare this paper and Diane Fuhrman for her efforts in manuscript preparation. The author is especially grateful for the major contributions of Kesley Edmo, Jr. and Maxine and Blaine Edmo. Finally, the author wishes to thank Rosella Moseley, Spero Manson, and the anonymous reviewers for their guidance and comments.

2. Throughout the paper this particular reservation is referred to as the "Intermountain reservation" and the tribe as the "Intermountain tribe" for anonymity.

3. Apache, Navajo, and Pueblo denote cultural types which are held in common by a number of tribes. For example, in New Mexico there are two separate Apache reservations where two distinct Apache tribes, the Jicarilla and Mescalero live. Similarly the Pueblo culture is represented by 19 different tribes in New Mexico (the Taos, Zuni, Acoma, Laguna, etc.) each having their own reservation.

34. The Intermountain tribal celebration is held in August of each year at the grounds and is now not only a premier event for Indians of many tribes, but it is also a source of true tribal pride.

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ARGUS LEADER EDITORIAL
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Work to solve suicide crisis
Tribes, state and feds seek answers

Rosebud is not the first South Dakota Indian reservation to struggle with a deeply troubling suicide epidemic among its youth. Standing Rock, Crow Creek, Cheyenne River - each tribe has lost far too many children in recent years.

But the scope of Rosebud's problem with suicide is shocking: a suicide rate of 141 per 100,000 people, compared to a national rate of 11 or 12 per 100,000.

The numbers describe the problem, but they do not explain its causes. Nor do they catalog the terrible web of lasting effects each successive tragedy brings upon families and friends. Those effects are too real and serve to perpetuate the problem. Suicide, we know, begets more suicide.

The roots of this circumstance are too deep to remove in a month, a year or even a decade: crushing poverty; an overmatched education system; a long-ago loss of traditional values.

But awakened to this crisis, we all must take any available steps to solve it. Already, tribes and government agencies are working to curb this horrifying trend:

§ The Rosebud Sioux Tribe invited the federal Centers for Disease Control onto the reservation to study the suicide epidemic and propose possible solutions.

§ Congress is moving closer to passing the first reauthorization of the Indian Health Care Improvement Act since 1994.

§ Rosebud's Suicide Task Force is marshaling local, state and federal resources to provide more counseling and education on the reservation.

§ Tribally-based, grant funded programs like Oniyapi on the Standing Rock Reservation and Peers Helping Peers at Crow Creek are working to engage at-risk teenagers.

These and other efforts are evidence of a broad community working toward a solution. That same sense of community - one that extends across racial and geographic lines - compels us all to take notice. It will, if we're lucky, be what guides us out from under this cloud.

If there are newer, better, more effective ideas with which to fight this crisis as it continues, we must employ them as they present themselves.

This problem touches us all; finding solutions falls upon all of our shoulders.

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KILLING THEMSELVES: RESERVATION SUICIDE SURGE
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Tribe takes steps to `stop this pain'
Rosebud Sioux embracing range of strategies to stem tragic trend

BY STEVE YOUNG

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MISSION - Two years after her son ended his life, Kathleen Wooden Knife finally has a reason to wipe away the tears.

A month ago, the resource development director for the Rosebud Sioux Tribe learned that a grant application she wrote had secured more than $477,000 from the Substance Abuse and Mental Health Services Administration to help prevent suicides on her reservation.

It was a major triumph for a tribe that has buried 28 of its members - most of them young people - because of suicides the past 3 years. And a triumph of the spirit as well for Wooden Knife, whose son, Casey Hunger, became part of that grim statistic on May 21, 2006.

"I am so ecstatic with happiness," she says. "I wanted to do my best with this particular project because I want to do what I can so other mothers would not have to feel this pain, this loss, this hurt in my heart."

Help can't come soon enough to Rosebud, where the numbers continue to mount. The reservation saw three more suicides in July. Fortunately, there are signs that tribal, federal and state efforts gaining traction on other reservations - Crow Creek, Cheyenne River and Standing Rock, in particular - have successfully stemmed suicide surges there, thus offering hope for families and officials at Rosebud.

The SAMHSA grant is the latest reason for optimism. That $477,570 will help establish the Wiconi Wakan Health and Healing Center in Rosebud, where the tribe will integrate its youth suicide and early intervention plans with its substance abuse programs.

That should take pressure off a task force formed three years ago to marshal prevention and intervention efforts among Rosebud agencies and programs. Since then, it has organized summits to educate youth and tribal employees on recognizing suicidal behavior and referring people for help, established a suicide

hot line on the reservation, created a video as an educational tool and put up billboards to increase public awareness.

"At the very least," said Tillie Black Bear, head of the task force, "we're challenging tribal members to address this issue in our families and communities."

But success certainly will require help from the outside, Black Bear and other tribal officials say. And the sooner, they add, the better.

In summer 2005, at a Senate Indian Affairs Committee hearing to discuss suicide among tribal youth, Indian Health Service Director Dr. Charles Grim told senators that his agency was expanding its research to learn why some tribes had greater suicide issues than others.

Three years later, baseline assessments across Indian County into the numbers of suicides, interventions attempted and who intervened have just been finished, said Dr. Phillip Smith, director of the IHS Division of Planning, Evaluation and Research. That will allow research into causes and associations to begin, Smith said.

But Rosebud officials say they can't wait. So early this year, they invited the Centers for Disease Control onto their reservation to study the suicide surge and to offer recommendations.

The CDC team studied medical and law enforcement records and conducted individual and focus group interviews. Its final report has not been released. But this summer, the CDC released preliminary findings that offered three suggestions for curbing the suicides - reducing risk factors, increasing protective factors and improving surveillance efforts.

Obviously, the CDC deduced, solving the intrinsic consequences of poverty, substance abuse and joblessness might be impossible. And even the more doable solutions - encouraging more early screenings for depression, increasing access to mental health and substance abuse treatments, and providing more support to suicide attempt survivors - requires resources the tribe might not have, the CDC conceded.

A key problem is the fact that the Indian Health Care Improvement Act hasn't been reauthorized by Congress since 1994. So per-capita spending for tribal people using IHS services is only $2,650 annually today compared to $5,298 for Americans as a whole.

At Rosebud, that means an IHS behavioral health staff that once numbered 11 mental health providers is now down to eight, including a secretary.

"It's clear, if you look at how budgets have been funded over the years, we have not had budget increases that kept up with inflation," said Dr. Peter Stuart, a national psychiatric consultant for IHS. "I certainly believe ... that behavioral health hasn't expanded quite as rapidly as general medical services, partly because of restrictions on how the funding is allocated."

Though South Dakota's congressional delegation thinks reauthorization finally will come this year, other tribes have pursued innovative programs to make up for the shortfall.

For example, the Standing Rock Reservation used emergency federal grant dollars to create a program called Oniyapi - or, roughly translated, "to live."

In Oniyapi, mental health paraprofessionals are sent out to homes to do follow-up on patients who have been seen at IHS facilities for mental health issues, and to provide case management if necessary.

This year, with funding from the tribe and the local IHS service unit, Standing Rock has brought in three clinical psychology interns to assist with behavioral health services. They do education in reservation communities, said Dr. Tami DeCoteau, who developed the intern program. They work in satellite clinics in Wakpala, Cannonball and Bullhead. And tribal vehicles are used to bring patients to the clinics if transportation is an issue for them.

"I put out a press release, and within two weeks we were able to fill these interns' clinical schedules," DeCoteau said. "I think they're going to make a huge difference."

It could make a difference elsewhere, too, DeCoteau said. She would like to expand the program to other reservations. There are plenty of clinical psychology candidates looking for internships, she said. And her tribe could be the administrative hub, taking care of all accreditation, securing money to pay for administrative fees and student stipends, and handling supervision of the students, she said.

"It wouldn't require other tribes to develop their own programs," she said.

It's an idea that has caught the eye of national IHS officials. "I would say we have a great interest in it," Stuart, the psychiatric consultant to IHS, said.

If the funding issues could be worked out, the Sanford School of Medicine's Department of Psychiatry would be willing to send psychiatric residents to the reservations as well, said Dr. Timothy Soundy, the department chairman.

But psychiatric residents need to draw a wage, he said, and faculty to supervise residents need to be paid. He has inquired about getting federal earmarks to pay for such a program, "but basically, I haven't had any luck."

"We're trying to go" to the reservations, Soundy said. "But the university is run in a state with no state income tax, and we have to make it financially viable. I think it would be excellent program."

Until then, there are other options that fit the CDC recommendations and apparently are working on other reservations that have seen suicide surges.

Since 2004, the Crow Creek tribe has pursued a program it calls "Peers Helping Peers." This summer, the tribal program offered up to 100 Crow Creek youths ages 14 to 18 a chance to make $100 by spending a week learning about suicide, teen violence, sexually transmitted diseases, and child and sex abuse.

They try to entice high-risk youth, said Lisa Thompson, executive director of Wiconi Wawokiya in Fort Thompson, which provides services for victims of domestic and sexual abuse. Along with learning how to recognize suicidal tendencies in friends and to refer them to help, the youths also spend time surveying their peers about any suicidal thoughts they might have had. And they try to sign others up for the class as well.

To get the $100, they must attend the entire week's worth of training, Thompson said. "I see it as a way, because of their time and commitment, to get them to come in and do this," she said of the payment. "It's an investment we make in the future of our children."

Tolly Estes, a community health aide for Indian Health Services who teaches the class, said it appears to be working. When it started in spring 2004, the tribe was averaging two to three suicide attempts a day, Estes said. By the end of that summer, the attempts were down to zero, he said.

Black Bear has traveled to Fort Thompson to learn about the program. It's being implemented at Rosebud now, along with other prevention and intervention efforts in schools, churches and nonprofit agencies that have come about thanks to Garrett Lee Smith Youth Suicide Prevention money provided through SAMHSA.

Those educational programs are an alphabet soup of acronyms - QPR, or Question, Persuade and Refer; safeTALK, or Tell, Ask, Listen and Keep safe; and ASIST, or Applied Suicide Intervention Skills Training.

They teach students, teachers, parents, clergy, coaches and other community leaders how to recognize suicidal tendencies in others and refer them on for help. It teaches them how to train others in the same programs, too.

Increasing youth activities and promoting healthy behaviors are keys as well, the CDC report said. On the Cheyenne River Indian Reservation, one answer was the building of the Cokata Wiconi Teen Center with a basketball court and Internet cafe.

The enticement is sports and the World Wide Web, said Julie Garreau, executive director of the Cheyenne River Youth Project. But once in the door, youths can learn about their language culture. They can get counseling. They can can take art classes. And they can find hope among the hopelessness.

"Can it be replicated? Absolutely," Garreau said. "Maybe it's not for every community. But here, kids say, `Wow, they built that for us?' I think it's made a difference."

It's certainly a piece of the puzzle, the CDC team said. And there are more pieces to be used, including better tracking of suicide-attempt victims after they leave the emergency room and a database that links information from law enforcement agencies and emergency medical services - even the coroner's office - where it involves those attempting or thinking about suicide.

All will be keys in bringing an end to Rosebud's suicide surge, tribal officials say. And when it does end, Kathleen Wooden Knife said, her tears will have been worth the effort and the heartache.

"Children can be lost in a moment's time. I understand that," she said.

"We're going to stop this pain any way we can."

To watch a short documentary on the battle to prevent suicides on the Rosebud Indian Reservation, as well as interviews with family members and others, log on @ARGUSLEADER.COM.

Searching for Solutions

As part of a three-day series about suicide on the reservations, the Argus Leader asked six state and tribal leaders what they are doing about the problem, and why South Dakotans should care about it. Two responses will be published each day.

Rodney Bordeaux

Rosebud Sioux President Rodney Bordeaux and his council declared a state of emergency in March 2007 because of a surge in sucides on their reservation.

Among the ways they are tackling the issue now is a new Wiconi Wakan Health & Healing Center the tribe will use to implement suicide intervention and prevention programs.

"We are humans like everyone else in this state," Bordeaux said. "Why does one look the other way if it is not one of us? It's what is happening today, and it's what happened when Columbus landed, and it's what happened at Wounded Knee.

"We are all guilty of this, even me, as long as it doesn't happen in my backyard.

"So you ask, `Why should people care?' This question should be asked of our own people. We need to come to grips with what is happening. Why did our own kill Crazy Horse or Sitting Bull? I believe I know why. This permeates down to today."

Angel Wilson

Angel Wilson's 19-year-old son, Clay, hanged himself Jan. 24, 2007, at their Soldier Creek home on the Rosebud Reservation.

Since then, Wilson, a nurse practitioner, has worked with a tribal suicide task force to bring an end to the suicide surge.

"The reason people should care is, Native American people have given up so much and lost so much," Wilson said. "To those people who say, `Native Americans are all dysfunctional. They're drunk and alcoholics,' I think that attitude is very short-sighted.

"I don't know how it can happen here, 200 miles away from Sioux Falls, and people not care. I can't believe that is how people feel, just from a humanitarian standpoint.

"But I also know the real answers are going to come from within our own community. We have to proceed with the assumption that we're not going to get any help, so we have to develop our own solutions."

How to get help

If you or someone you know is suicidal, here are resources to contact:

Æ The Native American Suicide Hotline is 877-209-1266.

Æ Residents in the Sioux Falls area also can dial 211 for the 211 HELPLine, or 605-339-HELP (4357).

Æ There is a national hotline number for people to call, 800-SUICIDE (800-784-2433).

Æ A second national number people can call is 800-273-TALK (8255).

Æ People looking for help on the Internet can go to the Suicide Prevention Resource Center at www.sprc.org.

Æ In South Dakota, information on suicide prevention is available at http://dhs.sd.gov/dmh/SuicidePrevention.aspx.

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Overwhelming sadness, anger, fear push Rosebud youths toward suicide
Steve Young
Staff
Staff

`An escape from this hell'
Survey finds what kids want: `Fix my parents'

BY STEVE YOUNG

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MISSION - Kaylene Snow Fly was upset with her boyfriend.

Derek Fiddler felt mistreated and unloved by his family.

So the young woman from Parmelee on the Rosebud Indian Reservation stepped into her bedroom closet late one night and tried to hang herself. And the young man from Green Grass on the Cheyenne River reservation, his wrists already scarred, climbed a tower in his hometown ready to leap to his death.

"I was like a lot of people on the reservation," Fiddler, 26, says, "looking for an escape from this hell."

National statistics show that tribal youths are two to three times more likely than other youths in this country to commit suicide. In this region of the Northern Plains, the rate is even higher - five to seven times more likely.

The reasons for this are myriad, observers say, from gang influences to a lack of spiritual values to the hopelessness forged from the consequences of poverty. But conversations with young people in Indian Country suggest that the "hell" described by Fiddler is much more complicated than all that.

"You can't say it is one thing," said Stephanie Metcalf, an 18-year-old technical school student in Bismarck, N.D., who is from St. Francis. "Some of it is over broken relationships. Some had kids and they couldn't raise them. Some have nothing at home."

The story of broken families is all too familiar to young people on the reservation. Parents can't find work in an environment with 80 percent unemployment. Alcoholism and absenteeism are rampant. Children are left to look after younger siblings for days and weeks at a time.

Metcalf tells the story of a 17-year-old friend in St. Francis who called her at 5 one morning. She was drunk; she wasn't even aware that it was Metcalf whom she called.

The girl's mother had hanged herself 10 years earlier, leaving behind three little children. She missed her mom, the girl told Metcalf. She was weeping, insisting that she didn't fit in with others. In time, her sobbing turned to anger, then silence.

Metcalf quickly rushed over and pounded on the friend's door. The girl's stepmother found her hanging, but alive.

Unfortunately, such stories resonate with many in Indian Country, and Fiddler is no exception.

As a 14-year-old growing up on the Cheyenne River Indian Reservation, he said his parents would leave him and his younger brothers "alone for weeks ... so they could go play bingo and go to the casino."

"We used to raise ourselves," he said. "We did the dishes. We made the food."

One day, he and a brother only a year younger were putting speakers together when the brother came across a rifle. He started playing with it, pointing it at people. Fiddler told him to knock it off and, believing he had made his point, wandered off to another part of the house to do something else.

That's when he heard the gunshot.

"It's a big transition, a big change in your life," Fiddler said, "when you watch your brother die in your arms at the age of 14."

His mother blamed him afterward, Fiddler said. That hurt because he loved his brother, he said, and because "what kind of person leaves their kids alone to go party?"

Eventually, the pain drove Fiddler up a tower at Green Grass to what he thought was the only remedy. He had gone halfway, crying and yelling at God as he went, the wind howling in his ears, when it occurred to him that "maybe this isn't the way to leave the world."

In a moment of reason - or maybe it was just panic, Fiddler said - he stepped back from his impulsiveness. Sadly, said Tillie Black Bear of the Rosebud Suicide Task Force, others aren't so fortunate.

So often, young people who attempt or complete suicidal gestures make those decisions under the influence of alcohol or drugs, Black Bear said.

"That's when they make decisions that are permanent," she said. "They don't see beyond the moment. Five minutes from now, they could be feeling something else."

At the time she tried to hang herself a year ago, Snow Fly, 20, said she wasn't despondent only because her boyfriend wouldn't come to see her, but she also was drunk.

"I never would have had the courage to do that if I was sober," she said.

The next day, home from the hospital and sober, Snow Fly said her family made it a point to tell her how much her attempt affected them, hurt them.

"You don't think about that," she said. "I felt bad for making them feel how they felt. I never attempted again. And I never would."

Tribal members worry that the kind of impulsiveness that inspired Snow Fly is the same mind-set that leads to copycat suicides and suicide pacts.

Cheyenne River suffered through such a pact four or five years ago when a group of young men drew numbers and then hanged themselves as their numbers came up.

On the Rosebud reservation, Bill Akard, an anthropologist at Sinte Gleska University in Mission, said a suicide eight to 10 years ago in Parmelee - and the reactions to it - raised the first red flags with him about copycats.

The victim was a young man who had no family and basically lived on the streets, Akard said. After his death, the community bought him a new suit, stuffed his coffin with toys and basically "showered him with more attention than he ever got in life."

"I was very nervous," Akard said, "about the subliminal message that sent."

Venerating suicide victims is something tribal officials constantly try to thwart, too. For example, in spring 2007, Todd County High School administrators refused to allow an elaborate memorial during graduation for a student who had killed himself the year before.

Allowing such ceremonies only makes heroes out of suicide victims, said the Rev. Jack Moore, pastor at Christian Life Fellowship in Mission. And he has a theory about that.

In the Lakota religion, there is no real concept of heaven or hell, only the concept of the spirit world, Moore said. So a young person who perceives no eternal consequence for taking his life might think "why not just go there" if he believes the spirit world will be better than the hopelessness he is experiencing in this world, Moore said.

"At the wakes and funerals we hold, we seem to bring honor to people that probably they would not have received if they were sitting in the room," he said. "It's that way with some of these suicides. They are made almost to be like heroes.

"Consequently, you can have someone sitting over there grieving the loss of a friend or relative, and they see this person lying in a casket and receiving all kinds of accolades and attention, and they can begin to think, `Why don't I do the same thing? Then maybe they will give me the honor and attention in a way that I've never been honored before.' "

In Rosebud, 15-year-old Megan Valandra concedes that she knows young people who attempted suicide because their friends had.

But even at her young age, Valandra also understands that it is never that simple. Many of the attempts she is aware of, some by children as young as 12, also were motivated by overwhelming sadness, anger and fear, she said.

"Some do it to get attention," she said. "But there are a lot of other things going on, too."

A survey of 187 tribal schoolchildren done a year ago bears that out. Asked what the tribe could do to help them with their sadness and problems, the children said such things as "fix my parents" or "help my parents be parents."

They demanded drug- and alcohol-free leadership and a ban on alcohol and drugs. They wanted to live in a safer environment and get rid of the gangs. They asked for more social outlets and more places to go so that they didn't have to merely roam the streets.

All of that, they said, would be a start.

But just as important for youth on the Rosebud reservation, who envision spending their lives in this not-so-perfect place that they call home, is that such efforts begin now.

"More to do would be nice," Snow Fly said.

"But I think their parents need to pay more attention to them, too. And I think we as young people need to listen to each other more."

Listen, she said, for the sounds and sights of hopelessness and despair.

Unfortunately on the Rosebud reservation, they aren't hard to find.

Reach reporter Steve Young at 331-2306.

To watch a short documentary on the battle to prevent suicides on the Rosebud Indian Reservation, as well as interviews with family members and others, log on @ARGUSLEADER.COM.

Searching for Solutions

As part of a three-day series about suicide on the reservations, the Argus Leader asked six state and tribal leaders what they are doing about the problem, and why South Dakotans should care about it. Two responses will be published each day.

Rep. Stephanie Herseth Sandlin

U.S. Rep. Stephanie Herseth Sandlin says suicide on the Rosebud reservation is so serious "that I told Chairman (Rodney) Bordeaux that `I'll do whatever you want me to do.'

" `If you want me to clear out my August schedule and be down there with you, I will do that.' "

In lieu of that, she supports reauthorization of the Indian Health Care Improvement Act, gets behind health care grants that the tribe seeks and tries to get earmarks for operating or establishing programs on the reservation.

"It's disheartening to me to have to address the discrimination or bias I think exists" in South Dakota, she said. "Or the attitude that the problem is so overwhelming that no one can do anything about it. Or that it's an Indian problem, and it

doesn't affect us.

"I don't think South Dakota can reach its full potential as a state. ... if we ignore 10 percent of the population and say, `It's an Indian problem; we don't have to worry about it.' "

Gov. Mike Rounds

Gov. Mike Rounds said a subgroup of the Zaniya Task Force, created by the 2007 Legislature to recommend ways to assure that all South Dakotans have access to affordable health insurance, is going to look at how the state can help improve behavioral health for tribal people.

He said the state also is trying to foster suicide prevention through federal grant dollars that it directs to reservations.

"We should care," he said. "These are South Dakota citizens. They have a joint citizenship; they are tribal members, but they are clearly South Dakota citizens, too.

"It's a sad state of affairs on the reservations, and these kids are stuck with it. They're going to grow up with kids that live off the reservations. And our young people will interact with these young people, even if they're from a rural part of South Dakota that seems miles away.

"Believe me, they will interact. So it's important that we care."

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Traffic ticket led teen to end life
Steve Young
Staff
Staff

Father laments `these kids with healthy minds and bodies just wasting it'
BY STEVE YOUNG

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ST. FRANCIS - For Lino Spotted Elk Sr., the senselessness of suicide is this:

His son, 19 years old and jailed on an old warrant for a speeding ticket, hanged himself on a summer night in 2005 after little more than an hour behind bars in Rushville, Neb.

It was a traffic violation, Spotted Elk repeats to himself. Three years after burying his son - Lino "JJ" Spotted Elk Jr. - this soft-spoken father still finds himself shaking his head.

"I never saw any indication that he would do something like this," Spotted Elk said, sitting in an office at the tribal courthouse in Rosebud, where he is the domestic abuse compliance officer. "I try to figure out what could I have done. You can beat yourself to death with those kinds of questions."

He does not suffer alone. In his office in Rosebud, tribal President Rodney Bordeaux recounts the troubling statistics - 28 mostly young tribal members dead by suicide in the last 3 years - and wonders aloud why the contagion seems localized to his reservation.

There are many tribal youths in border towns near the Rosebud reservation, in Bonesteel and Winner, Gregory and White River, Bordeaux said. Those kids face racism every day. They deal with poverty and alcoholism issues.

"Yet they don't seem to have the suicide issues we do," he said. "That's what is so puzzling. Why are our students hanging themselves when they have the opportunity to live?"

One answer, the senior Spotted Elk said, is just that - opportunity. Youths in border towns have access to more sports complexes, to get into baseball and basketball leagues, to go to movies, he said.

Earlier this decade, he was part of a program that opened the St. Francis school gym on Friday and Saturday nights. Young people lined up to get in, he said. They had deejays and dances, and local businesses donated food.

"There were rules," Spotted Elk said. "No fights. No profanity. No gang affiliation. If you had any unexcused absences from school, you couldn't come to open gym.

"If the kids were at one of these events, it made it easier for all of us. They weren't out breaking windows and destroying your property."

But like many things on the reservation, politics and the end of grant dollars shut the gym doors, Spotted Elk said. With nothing to do, many youths became more susceptible to the negative influences.

His son apparently was no exception. For one thing, he hung out with what his father called "the local wannabe gang members."

"I told him, `If you hang with them, they're going to associate you as a gang member,' " Spotted Elk Sr. said. " `When you hang with those kinds of boys, you probably are going to get into trouble.' "

JJ Spotted Elk found that trouble. He was 16 when he and some others broke into a store in Rushville. Because his father worked in law enforcement at the time on the reservation, authorities in Rushville were willing to release the boy to his father if he paid restitution.

But the younger Spotted Elk spent 30 days in jail before he finally called his dad and said he was ready to come home.

Why did he wait so long? Looking back, Spotted Elk Sr. thinks maybe some of his son's hesitancy was a result of his parents' divorce years earlier. The children had bounced back and forth a lot after their parents' breakup. The rules were different in each household, Spotted Elk Sr., said. The expectations were different as well. At his house, his son had curfews. He wasn't allowed to hang out with the gang wannabes.

It caused friction.

JJ Spotted Elk had no strong spiritual base, either, his father said. He didn't go to church. And though the senior Spotted Elk tried to take him to Lakota sweat ceremonies, his son balked.

"He'd say, `Mom doesn't want me to' or `I don't want to,' " Spotted Elk Sr. said. "I'd try to tell him, `You need to believe in something.' Maybe I should have been more forceful."

Instead, the influences he saw on his son's life were from MTV music videos, rappers and gangsta music.

"They want to be like P Diddy or 50 Cent," Spotted Elk Sr. said. "It's crazy. That stuff floods our reservation, and they want to be like that."

It's a make-believe life that doesn't begin to mirror what the elder Spotted Elk knows to be true on the reservation. And what he knows only makes acts such as that committed by his son seem more senseless.

The senior Spotted Elk has worked in emergency medical services on the reservation. He has served as a tribal and county coroner at different times as well.

Like few others who call Rosebud home, Spotted Elk Sr. has worked the most horrific accident scenes. He has witnessed the most wrenching moments between life and death.

And so for Lino Spotted Elk Sr., the senselessness of suicide is this:

In St. Charles Catholic Cemetery in St. Francis, there are two gravestones side by side. One is for his son, the other for an infant daughter, Angeline Dorothy Spotted Elk, whose fragile life ended after barely 10 months.

As he glances back and forth between the two, a father only can shake his head and wonder why.

"To see this population group struggling to make it to the next day," Spotted Elk Sr. said, "and to see these kids with healthy minds and bodies just wasting it. That is hard to take."

ABOUT THE REPORT

Argus Leader reporter Steve Young and photographer Lara Neel began working on this series July 1, when the Rosebud Sioux Tribe held a two-day summit to address the issue of a surge in youth suicides on its reservation.

Young and Neel spent three weeks traveling to the Rosebud reservation, and to other reservations in South Dakota, to learn about the problem and what tribes have been doing to combat it.

SUNDAY: The Rosebud Sioux Tribe is 15 months into a state of emergency brought on by an alarming number of suicides. Tribal officials and members, plus other professionals, are struggling to stop the tragedy.

MONDAY: Native American youths talk about suicide on their reservations, from why their friends are killing themselves to what they think would make a difference.

TODAY: As the Rosebud Sioux work to drive away "the spirit of death" from their land, they can consult with other tribes to find out how those tribes handled suicide surges on their reservations.

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For troubled girl, suicide seemed like end to suffering

Steve Young
Staff
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STORY BY STEVE YOUNG
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MISSION - By age 14, Lucy Crane knew enough about life on the Rosebud reservation that she thought maybe death could be better.

A teenage girl can bottle up a lot - despair over friends killed in car accidents, doubts created by not knowing your biological parents, tensions born of trying to be a friend to gang members as well as straight-A students.

But when it all became too much, instead of turning to someone who could help her sort through the emotional chaos, Crane reached for a bottle of pills or a blade instead.

"I kept it inside too much and couldn't handle it," she said. "I guess I saw suicide as my way out."

That's an attitude that doesn't surprise Tillie Black Bear, chairman of the Rosebud Suicide Task Force. She is convinced that it exists to a greater extent than many people on her reservation are willing to believe.

"There's probably a higher percentage of depression among our youth than we realize," Black Bear said. "The denial among schools on the reservation, among the families and the health-care professionals ... is probably the greatest reason why so many attempts are made."

Crane, now 21, estimated that she made at least seven attempts - mostly at her home in St. Francis with Tylenol or prescription drugs, though the scars on her wrists reveal another method as well.

In some ways, the tensions she experienced growing up were typical of any child. Raised by an aunt, she bristled at having to do chores while friends roamed freely, doing whatever they wanted. She had a curfew when others stayed out to all hours.

But Crane also was exposed to a world of alcoholism, poverty and gangs that many South Dakota teens living off the reservation never experience.

Some friends couldn't go to school because they had to stay home and look after inebriated parents. And some learned from Mom and Dad well - seeking solace from their own inner pain through alcohol and drugs.

Part of her problem, Crane said, was her need to maintain friendships with everyone, whether they were a destructive influence on her life or not.

"Friends I hung out with were into drugs," she said. "I followed them into drugs. I got high. I moved away from my house. I stole cars. I followed them to fit in. In order to keep my friends, I have to do what they're doing."

Or at least she thought she did. Unfortunately, when she tired of that lifestyle, Crane discovered it wasn't easy to break free.

"They would call me down and try to fight me," she said of her gang friends. "They'd say I was weak and cut me down to where I'd finally just go back and do things with them again."

The frustration that she felt she kept inside. Not knowing how to escape, she contemplated death.

Looking back now, Crane said many of her attempts probably were nothing more than cries for help.

"I don't think I was always doing it with the idea of really killing myself," she said. "I did it to reach out and get someone to listen to me."

But on at least one occasion, she was rushed unconscious to the emergency room in Rosebud. What she remembers of that experience was the feeling of falling through a black hole.

"It really scared me," she said. "These hands or these things ... I'm not sure what they were ... kept reaching at me. I think maybe they were trying to take me to hell."

But it wasn't the fear of eternal damnation that finally convinced the teenager to quit hurting herself. That didn't happen until around New Year's five years ago when, as a result of running away from home and cutting her wrists, she was sent to the Human Services Center in Yankton.

Three months among the seriously mentally ill convinced her that she didn't need the attention her suicide attempts brought.

"That was scary," Crane said. "I saw people and heard people ... who really had lost their minds. That made me think, `I should quit what I'm doing. If I take one more overdose, I could lose my mind.' "

Today, she is a young mother, with a 2-year-old daughter, Drayleen, and a month-old son, Drayden. The children's father is in jail, Crane said. It would appear that the life she faces today as a Rosebud Sioux woman in her 20s isn't all that much easier than it was back when she was just a young girl in her teens.

She hopes her children never have to come to know that life. It would help if they had more to do on the reservation, Crane said - a swimming pool, a nice basketball court or maybe an arcade.

Mostly, she said, just having more people willing to listen to a teenage girl whose friends have died in a car accident, or whose parents are absent all the time, would be nice.

"That would make things better," she said. "If there had been someone there to talk to, I probably would have talked to them. I probably never would have done what I did."

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Why are so many young Lakota Killing Themselves?
Steve Young
Staff
Staff

Survivors, tribe struggle to find answers
South Dakota reservation's suicide rate said to be among highest in world

STORY BY STEVE YOUNG

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MISSION - In the hospital that evening, sobbing, wracked by despair, Marie Wilcox cried out in the sorrow of a mother and a nation.

Hours earlier, she had returned to her trailer east of Mission to find her 18-year-old son, Stoney Larvie, hanging from the rafters on their deck with a dog leash around his neck.

Now in the emergency room in Rosebud, an inconsolable Wilcox lashed out as she tried to fix blame for her loss and find answers for an act she never saw coming.

"I was mad at him. Maybe a little bit, I'm still angry," Wilcox, 41, says. "He gave up on me. He gave up, for what reason, I don't know. And not understanding why hurts the most."

It is a pain felt across the Rosebud Reservation in south-central South Dakota today by a people, the Sicangu Lakota, who are struggling to understand the spirit of death that has descended upon their homeland.

Other reservations in the state have experienced suicide outbreaks in recent years. But on Rosebud the numbers are higher, the duration longer, than elsewhere. The usual tactics for curbing the behavior don't seem to be working.

Since 2005, at least 28 tribal members - most of them teens and 20-somethings - have killed themselves by hanging, overdosing on drugs or slashing their wrists. Sports stars and student scholars are among them. So are the broken spirits born of alcoholic and impoverished homes.

In 2007 alone, the reservation's suicide rate soared to 141 per 100,000 people - and a staggering 201 per 100,000 for males ages 15 to 24, what some experts call among the highest incidence in the world.

That compares to a national rate in America of 11 or 12 per 100,000.

"It is an epidemic," said tribal President Rodney Bordeaux, whose tribal council declared a state of emergency because of the suicides in March 2007. "The professionals tell us this kind of thing is cyclical. But we're going on three years now. We want it to stop."

In an effort to rein in the numbers, the Centers for Disease Control sent in a team early this year to assess the problem and look for solutions. Its report isn't final yet.

The Department of Health and Human Services responded as well, marshaling additional mental health providers to help Indian Health Service specialists already stretched to the limit.

Meanwhile, a coalition of tribal individuals and agencies called the Rosebud Suicide Task Force has taken the lead in the battle. Federal dollars and state suicide prevention specialists have been used in schools and in reservation communities to teach students, teachers, tribal employees and local leaders how to recognize suicidal tendencies and direct those affected to help.

Public service announcements, billboards and prevention videos have been produced. Task force representatives have gone out to other reservations that have endured suicide surges to see how they are combatting the problem. And the tribe recently was awarded almost $500,000 to establish a place from which to implement its suicide prevention strategies.

Yet for all that, the numbers in 2008 remain troubling on the Rosebud Reservation.

There were three suicides in July alone, pushing the total to eight for the year. By mid-July, mental health providers had reported 1,849 visits to the Rosebud Comprehensive Health Care Facility where the primary purpose for being seen was suicidal inclinations. That number included an astonishing 68 visits by children 1 to 4 years old.

"A lot of that is modeling behavior," Dr. Dan Foster, a clinical psychologist for IHS in Rosebud, said at a suicide summit in July of the youngest patients.

"Some suicides have been very public, hangings in backyards. So many of these little ones we see have witnessed or been affected by it."

Certainly, what's happening now at Rosebud is not unique to South Dakota, or to Indian Country across America. Pierre saw a surge in the 1990s. And earlier this decade, the Crow Creek, Cheyenne River and Standing Rock reservations all experienced surges in suicide.

Five years ago on the Crow Creek Reservation, his tribe "was averaging two to three attempts a day," said Tolly Estes, a community health aide for Indian Health Services. And in 2005, Julie Garreau, executive director of the Cheyenne River Youth Project, testified before a U.S. Senate Indian Affairs Committee that her reservation was seeing three to seven suicide attempts every week.

Among those was a highly publicized suicide cluster in which young men made a suicide pact with each other, drew numbers and then hanged themselves in order as their numbers came up.

But why? What is it about reservation life today that has fostered such despair?

At a suicide summit in July in Mission, tribal officials indicated that there had been 519 suicide attempts or gestures from Jan. 1, 2005, through this past June 27 on the reservation. Of those surveyed afterward about the leading contributing factors to their attempts:

§ 136 referred to the death of a friend or relative.

§ 127 talked about a history of substance abuse or dependency.

§ 97 had experienced a divorce, separation or breakup of a romantic relationship.

§ 91 pointed to the suicide of a friend or relative.

"Obviously, it's much more complicated than all of that," said Dr. Pat Iron Shell-Hill, mental health director for the Wanbli Wiconi Tipi juvenile detention center west of Mission.

"There's no one answer. Parenting, gangs, poverty ... they all play a role."

Many point to the historical trauma inflicted upon a horse-and-buffalo society whose culture and land were decimated by the U.S. government.

At Rosebud, as elsewhere, the Lakota once were a people of extended families living in camps that eventually evolved into reservation communities today called Upper Cut Meat, Two Strike and He Dog, said Bill Akard, an anthropologist who teaches at Sinte Gleska University in Mission. They ruled over themselves and made decisions based on what was best for the family, Akard said. But the reservation system that gave rise to cluster housing, relocation and a style of government foreign to them changed all that.

"Cluster housing made a point of breaking up families," Akard said.

"And the corruption you see in politics now on reservations is a product of the system. Before, people you represented were your relatives. Now you're not related to the people you represent. You don't owe them anything."

Against that backdrop, many have left the reservations, weakening extended families even further. And exacerbating the plight of those who remain was a federal policy of trying to integrate the Lakota into mainstream society by banning their language and religion, particularly in the boarding school settings, Akard said.

Mix in the consequences of living in what are now some of the poorest places in America, "and you can see how it leads to hopelessness and to suicide," he said.

It's a hopelessness revealed, for example, in high school dropout rates. In fall 2004, 256 students started at Todd County High School as incoming freshmen. This spring, 56 of them graduated, according to Bryan Burnette, who works in student information support for the school district.

"Education plays a big role in students' levels of confidence and self-esteem," Burnette said.

"You can see what these numbers show."

In families that are no longer intact, children don't get to be children, Akard said. Many don't even get to go to school.

"I've heard children say, `All the adults are drunk,' " he said. "Or, `I had to go get the groceries. I had to watch the baby.' Or, `I had to go get the medicine. I never got to be a kid.' "

That's a story to which many young people on the reservation can relate. In Rosebud, 15-year-old Megan Valandra estimates that at least half of her friends have attempted or thought about suicide, often because of situations at home.

"Usually they are taking care of younger siblings because of alcohol or drug problems with their parents," she said. "Sometimes it's over a relationship. ... they broke up with a boyfriend or girlfriend.

"But there was a freshman that did it because of family problems. Another was family problems. And some kids probably had problems at school."

At its worse, the despair can reach all the way down into early childhood. The Rev. Jack Moore, pastor at Christian Life Fellowship in Mission, said he once asked a fourth-grade boy what he wanted to be when he grew up.

"He said, `I probably won't grow up. I'll probably just be a drunk,' " Moore recalled.

At the juvenile detention center, where Iron Shell-Hill works at convincing young people of the value of their lives at 30, 40, 50 and beyond, "they just tell me how many times they've attempted suicide," she said. "They say, `I'm not going to live beyond 20.' "

Observers say another critical influence on self-esteem and self-worth on the reservations has been the rise of gangs, especially in the past 10 to 15 years.

Young people who get no sense of nurturing, support or belonging at home find it now in the gang colors of the Crips, Bloods and others.

Iron Shell-Hill talks about young boys being beaten as part of the rituals to join gangs, or to leave them. And, similarly, girls are "sexualized," Iron Shell-Hill said, as part of the same rituals.

"I've heard some young boys, 9 and 10 years old, who outside of their families say, `I'm trying to decide what gang I want to get into,' " she said. "That's because there isn't enough active parenting going on to dissuade them."

In a survey of Todd County students a year ago, the biggest complaint was that young people didn't feel safe for fear of gangs. And some professional people working on the reservation say they have discussed with their spouses allowing teenage children to join gangs simply as a way to provide them protection from other gangs' members.

Tribal President Bordeaux said even his family has been touched by the issue. In 2002, his kindergarten-age son was transferred out of Rosebud to a country school "basically because of bullying and no intervention by the teacher," Bordeaux said. "He refused to go to school."

Christopher Grant, a national Native American gang specialist based out of Rapid City, said suicide probably is an option that someone trapped in gang involvement considers.

"They don't see a way out," Grant said. "Their friends don't want them to leave, they are being assaulted if they leave and, most importantly, the enemies they've made don't recognize them as no longer being gang-involved.

"I can certainly see scenarios where young people ... see suicide as the only way out."

While gang pressure certainly can be a factor, it doesn't fit all suicides, said Dr. Dan Foster, the clinical psychologist at the Indian Health Service in Rosebud.

Rather, the two common denominators he sees most often in those who attempt suicide are the presence of intense psychological pain and the absence of meaningful spiritual values.

"Their parents may embrace some kind of spirituality, or their families do, like attending sun dances or going to church," Foster said. "But these young people don't embrace anything. You see a great vacuum in the things directing them."

Some blame the boarding schools for that. With their native language and religion banned in the schools - and the practice of their sacred pipe rituals outlawed by the U.S. government until the late 1970s - generations of Lakota simply fell away from any kind of religious practices and never found their way back.

So if you ask youth on the reservation today what they believe, "the majority won't be able to tell you," said Moore, the pastor at Christian Life Fellowship. "They can't tell you if they're religious. They can't tell you if they have a relationship with God.

"What does that mean? It means our children are beginning to act on instinct rather than conscience. If you're operating on instinct, you develop a survival mode. Conscience is what keeps mankind from destroying mankind."

Her son was not a churchgoer, Marie Wilcox said. He didn't attend sweat ceremonies or sun dances.

But he wasn't into drugs or alcohol, either, she insisted. And what makes it so confusing is that her son had his passions - sports, fishing, his girlfriend.

That's why now, more than two years since his death on May 12, 2006, it continues to makes no sense to her and a reservation desperately looking for answers.

He left no note, no explanation except a supernatural encounter that Wilcox said she had with him the evening after he died.

She was in the hospital, Wilcox said, when "I felt his spirit. He put his arms around me and said, `Don't do that. Don't blame anyone.' I said, `I won't. Just come home.' "

But he never did, of course, she said. He just walked away, never turning around, leaving a mother to grieve and the Rosebud nation to wonder why.

Reach reporter Steve Young at 331-2306.

ONLINE

Watch a short documentary on the battle to prevent suicides on the Rosebud Indian Reservation, as well as interviews with family members and others. Log on

@ARGUSLEADER.COM.

how to get help

If you or someone you know is suicidal, here are resources to contact:

Æ The Native American Suicide Hotline is 1-877-209-1266.

Æ In Sioux Falls, the Suicide Prevention Hotline is 605-339-8599.

Æ Residents in the Sioux Falls area also can dial 211 for the 211 HELPLine, or 605-339-HELP (4357).

Æ There is a national hotline number for people to call, 1-800-SUICIDE (1-800-784-2433).

Æ A second national number people can call is 1-800-273-TALK (8255).

Æ People looking for help on the Internet can go to the Suicide Prevention Resource Center at www.sprc.org.

Æ In South Dakota, information on suicide prevention is available at http://dhs.sd.gov/dmh/SuicidePrevention.aspx.

Searching for Solutions

As part of a three-day series about suicide on the reservations, the Argus Leader asked six state and tribal leaders what they are doing about the problem, and why South Dakotans should care about it. Two responses will be published each day.

Sen. John Thune

"This is in our backyard," said Republican Sen. John Thune, who voted this year to reauthorize the Indian Health Care Improvement Act and also helped to secure $200,000 for suicide prevention services on the Rosebud Indian Reservation. "It's like your neighborhood. Our common humanity should suggest that we want to solve this problem, not to mention that issues like this can spill over to nonreservation communities. And that can create all kinds of tangential problems.

"I think a lot of people look at reservations, because they are so far removed from where they live, with kind of a benign neglect. `Yes we should do something about that, but it really doesn't affect me.'

"I think a lot of members of Congress look at it that way. But for us in South Dakota, this is a lot closer to home. It ought to create more of a motivation for people in South Dakota to do something about it."

Sen. Tim Johnson

"As a father and grandfather myself, I cannot stand to witness the loss of a young life," said Democratic Sen. Tim Johnson who, like Thune, voted to reauthorize the Indian Health Care Improvement Act, worked to get $200,000 to support suicide prevention programs on the Rosebud Reservation and has found financial support for the tribe's wellness and youth programs.

"This is not just a crisis of Indian reservations, but a crisis that threatens the economic and public health of our entire state. The health of our state and country is a complex network that cannot be isolated into regions or racial groups. ... (Suicide) makes our whole society a more painful place to live.

"While the families and communities closest to crisis feel the most painful effects, we are all impacted by slowed productivity, health care expenses and the loss of opportunity that exists in each of these young people."

Argus Leader

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Despitestable home, teen chose death
Steve Young
Staff
Staff

Mother struggles to understand reasons behind son's tragic act
BY STEVE YOUNG

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SOLDIER CREEK - He died on a Wednesday morning, a bitter January day almost 20 months ago, with a cord around his neck and an unquenchable pain in his soul.

In those ways, 19-year-old Clay Wilson typified the contagion of suicide that has spread across the Rosebud Indian Reservation.

But unlike many of the 28 self-inflicted deaths that have left this tribe reeling over the last 3 years, Wilson did not fit easily into the stereotypes of young suicide victims on the reservation.

He did not struggle with substance abuse problems, said his mother, Angel Wilson. Nor did her son know the hopelessness of a home broken by unemployment, alcoholism and dysfunction.

"It makes it more difficult to understand," Wilson, a 48-year-old nurse practitioner, said as she sat at the kitchen table in her log home west of Mission. "He had a loving mother, a stable home. And I know that he was very loved by the rest of his extended family."

Still, for all that love, Clay Wilson was tormented, too. He suffered from depression for years, a condition his mother thinks could have been organic in nature and was largely undiagnosed.

"Early on, it was hard to sort out," she said. "You wondered, `Is there something organic going on here, or is it behavior they can treat with medication coupled with talk therapy?'

"I know he got really good at hiding it. After he died, his girlfriend was going through his dressers, and we found a letter he wrote when he was 9 years old, where he talked about wanting to die. I can't imagine how he hung in there for 10 years."

While Clay Wilson was good at shielding his mother from the demons within him, he couldn't escape all the harsh forces that typify life for young people on the reservation.

Her son was in middle school, Angel Wilson said, when he was drawn into gang activity. He became increasingly defiant. He found himself in trouble with the law. And there was the fighting.

He didn't go out looking for trouble, according to his mother. It just seemed that there was always someone who wanted to test him.

"He'd always just answer me by saying, `Mom, you don't know how it is,' " Angel Wilson said.

When his personal struggles followed him into Todd County High School, Wilson missed a lot of school. In time, he and his mother agreed that he needed to get away, so he transferred to Roosevelt High in Sioux Falls.

"It was a way to get away from the peer pressure, the negative things ... like the gang activity," Angel Wilson said.

He liked Sioux Falls. But in time, he grew lonesome; he missed his family. And so he came home.

Back on the reservation, it wasn't all torment for Clay Wilson. He loved to hunt for deer and turkey and elk, and even acted as a hunting guide for others.

He was a fisherman, too, and played baseball and basketball. At 5-foot-9, 160 to 170 pounds, he even found satisfaction on a football field toward the end of his life.

"They tried to get him to be a running back," his older brother, T.J., said. "But he wanted the defensive line. He didn't want to be hit. He wanted to do the hitting."

Acquaintances say he eventually weaned himself from the gang influences and even shielded younger children from the gang predators on the school buses.

But Clay Wilson never could tame his depression. His mother said summers were better. He had a girlfriend. He had things to do. Then winter would come, and he would stop taking his medication.

"A couple of times, I had to forcefully have him put in the hospital because he was threatening suicide," Angel Wilson said.

In spring 2006, two of his good friends committed suicide. The first, Stoney Larvie, hanged himself on the deck of his home east of Mission that May 12. Nine days later, on May 21, Casey Hunger followed him to the grave.

"He was angry that they would do that," Angel Wilson said. "He got depressed and wouldn't take his medication.

"You know, I ask the question a lot, `If his friends had not committed suicide, would he still be here?' I think he would be."

Instead, Clay Wilson's despair festered. His mother said she thinks he might have overcome that anguish if he'd had a spiritual base upon which to lean. But the seeds she had tried to plant - the faith-based basketball camps, the traditional Lakota sweat ceremonies they attended - never took root.

"He lost faith in a lot of things," Angel Wilson said. "He was a realist; he saw things the way they really were. He didn't buy into the spirituality."

On that January morning in 2007, just three days after his family celebrated his 19th birthday, Clay Wilson waited for his mom to go to work and his girlfriend to head into town and then hanged himself in his basement bedroom at his mother's home.

Today, Angel Wilson prefers not to dwell on the chaos of that morning - of the girlfriend who found her son, cut him down and frantically tried to perform CPR on him.

Instead, she walks down the path from her house to her son's grave, sits on a bench there at least once a week and speaks softly to him as she studies mementos that family and friends have left to honor him.

There are the accessories of a hunter - a cap, a knife and gloves. Somebody left a dollar bill; someone else, a horseshoe. And there is an invitation to a wedding of which he would have been part.

Angel Wilson said she believes her son is aware of it all. Though he wasn't spiritual in life, she is convinced that he talks to her in ways that are spiritual - almost supernatural - now.

For example, he visits his 4-year-old niece, Kiera, in her dreams, Angel Wilson said.

And she tells the story of how this past January, as she stood at his grave on the anniversary of his death, a buffalo that had been wandering the countryside for months appeared nearby.

Steam billowed from the beast's nostrils as he stood silent in the numbing cold. It was, Angel Wilson said, "almost spiritual."

So, too, was an incident that happened the day before, she said. She had been going through some files when she found a note that her son had written to her. Funny, she thought, but she hadn't seen that there before.

" `You taught me after every dark night, there's a brighter day!' " the note read. " `Love you, Mom. Thanks for every blessing you taught me. You mean the world to me.' "

She smiled, Angel Wilson said. And now there is no question in her mind.

"I know his spirit is in the next world," she said. "I know he's where he needs to be. And that's all I need to know."

July 3, 2008
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Tribe seeks solution to suicides
Steve Young
Staff
Staff

BY STEVE YOUNG
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MISSION - A year into a state of emergency because of suicides among their youths, Rosebud Sioux tribal officials grappled with possible solutions Wednesday.

After two days of meeting at Sinte Gleska University among state, federal and tribal officials, the Rosebud Sioux Tribe Suicide Prevention Task Force released a 20-item action plan that involves mainly tribal people helping themselves.

Among the solutions:

§ More training for youths to help them look and listen for warning signs among their peers.

§ More emphasis in schools on cultural and traditional values, with tribal elders as mentors.

§ More outreach on reservations to parents and leaders to educate them on suicide prevention.

"I really believe there is more hope this year that, with all the work being done by the administration and the task force and the other supportive agencies, we're going to stop it," said Tillie Black Bear, head of the suicide task force.

The tribe is awaiting an epidemiology study by the Centers for Disease Control and Prevention that might help it understand why youths are killing themselves.

But Janel Sully, a tribal judge who works with children, has a hypothesis. Reports from treatment centers in Huron, Parkston, Yankton and elsewhere suggest that tribal youths have no strong belief in a higher power.

"We've got to make sure our kids realize their spiritual ties and that it is practiced," Sully said.

Dr. Dan Foster, a psychologist with Indian Health Service in Rosebud, sees two common denominators among those attempting suicide.

One is "a tremendous psychological pain," Foster said. "And there is an absence of a spiritual belief that gives them a direction for coping. Whether it's religious or cultural or even personal, it's not there."

Of the 519 suicide attempts or gestures reported by Rosebud residents since Jan. 1, 2005, 136 listed the death of a friend or relative as a leading contributor to their action, according to tribal reports. Another 127 listed a history of substance abuse or dependency, while 97 pointed to a divorce or separation. Another 91 blamed their attempt on the suicide of a friend or relative.

The tribes' work to stop suicides, Black Bear said, starts with families.

"I think the suicides would stop if we went back to the families and supported them in returning to the whole healthy image of the family," she said. "That's where it has to begin."

SOUTH DAKOTA RESIDENT AMERICAN INDIAN DEATHS DUE TO SUICIDE BY AGE AND YEAR OF DEATH, 1990-2007

Year of Death	Total	< 18	18+
1990-2007	303	50	253
2007	20	2	18
2006	21	4	17
2005	18	5	13
2004	25	7	18
2003	14	2	12
2002	17	5	12
2001	19	3	16
2000	14	4	10
1999	12	1	11
1998	19	2	17
1997	22	3	19
1996	14	2	12
1995	15	2	13
1994	17	2	15
1993	13	0	13
1992	14	3	11
1991	10	0	10
1990	19	3	16

Source: South Dakota Department of Health

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Youth Suicide in New Mexico: A 26-Year Retrospective Review*

ABSTRACT: Although suicidal behavior in children and adolescents is a major public health problem, large-scale research on suicide in this population is uncommon. In this study, we reviewed autopsy and field reports for all pediatric suicide cases referred to the New Mexico Office of the Medical Investigator from 1979 to 2005. The age-adjusted suicide rate was 4.8 per 100,000. Psychologic stressors and parasuicidal behavior were identified in some cases. Seventy-six percent of suicides occurred in the victim's home or yard, and 25% left a suicide note. In 26% of cases, alcohol or other drugs were detected in postmortem. Gunshot wound was the most common method overall (58%), followed by hanging (30%). Although the age-adjusted suicide rate is higher in New Mexico than nationally, the trends in the population are similar. With a solid understanding of the circumstances, it may be possible to predict, and hopefully prevent, future cases of child and adolescent death.

KEYWORDS: forensic science, epidemiology, suicide, adolescent

Suicide is a tragic and potentially preventable public health problem. Whereas suicides account for 1.3% of all deaths in the United States annually, they comprise nearly 12% of deaths among 10- to 24-year olds (1). Although the overall rate of suicide among youth has declined slowly since 1995, several states have seen no significant change in rates over the past 10 years, and some (including Hawaii, Oklahoma, Nebraska, Nevada, and New Mexico) have even seen increasing rates in this time period (2). Suicide remains the third leading cause of death nationwide for people aged 10–24, and is the second leading cause of death in a number of states, as well as among Native Americans, in this age group (2).

The number of completed adolescent suicides reflects only a small portion of the impact of suicidal behavior. Many more young people are hospitalized as a result of nonfatal suicide attempts than are fatally injured, and a still greater number are treated in outpatient settings (or are not treated at all) for injuries resulting from suicidal acts (3,4).

Deaths and injuries from suicidal behavior represent a substantial drain on the economic, social, and health resources of the nation. Suicide accounts for $25 billion each year in direct costs, including healthcare services, funeral services, autopsies and investigations, and indirect costs such as lost productivity (3). One public health approach for the prevention of suicide involves identifying and providing treatment for those individuals who are at high risk for suicide.

While suicide is often viewed as an impulsive response to a single stressful event, it is typically a far more complicated issue, resulting from complex interactions between biologic, psychologic, social, and environmental factors. As cited in the suicide literature, predisposing characteristics for suicide include mood or psychiatric disorders, chronic family disorganization, and a history of physical or sexual abuse (1,3,5,6). These characteristics in combination with acute or proximal stressors, such as a fight with a parent or significant other, or being expelled from school, may stimulate suicidal ideation. Researchers tend to conceptualize suicidality as a continuum extending from thoughts about suicide that are not acted upon, to nonfatal suicidal acts, to completed suicide (3,5). Factors that may enhance the risk of acting on suicidal thoughts include access to lethal means, a tendency toward impulsive behavior, and a sense of hopelessness or pessimism (3–5). Current youth suicide prevention efforts are focused on school-based education programs for raising awareness of suicide and its risk factors, screening for "at risk" youth and directing these youth into appropriate mental health treatment; crisis intervention through suicide hotlines; and reducing access to lethal means (particularly through gun control measures) (3,5,6). However, the rate of suicide and attempted suicide has not changed dramatically in the recent past, despite advances in psychiatric and mental health treatment, suicide prevention and awareness programs, and reorganization of health services (1–3).

There is some indication that rates of suicidal behaviors and suicide risk profiles can vary widely among distinct social and cultural subgroups (5). Suicide is far more common among some groups of teens than others; for example, male teens are still almost five times more likely than females to die by suicide, even though females are more likely to attempt suicide (3–5). While white males account for the majority of youth suicide deaths nationwide, the suicide rate among Native American male youths is still exceedingly high in comparison with the overall rate for males 10–19 (16.0 per 100,000 vs. 7.8 per 100,000) (2). And although still relatively low (5.7 per 100,000 in 2000), the suicide rate has been increasing rapidly among African American males 10–19, doubling over the last 20 years (6,7). The stability in suicide rates among young people overall and the increasing rates in certain populations of youth suggest that current prevention strategies are not universally applicable. Research is needed to show which risk and protective factors are most relevant in this age group.

The substantial proportion of youth and the robust mix of ethnicities in New Mexico provide an opportunity to study a diverse group of youth suicide completers, including those less represented in national or other regional studies. In 2005, a total of 80% of the

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U.S. population was White, 13% Black, 1% American Indian/Alaska Native, and 14% Hispanic or Latino. In New Mexico, 85% of the population was White, 2% Black, 10% American Indian/Alaska Native, and 43% Hispanic or Latino, and >25% of the population was under 18 years of age (8). The New Mexico Office of the Medical Investigator (NMOMI) is the statewide, centralized medical examiner agency for New Mexico, and investigates all deaths in the state that are sudden, violent, unexpected, or unattended by a physician. Although OMI does not have jurisdiction on federal lands (military installations and American Indian reservations), the agency is frequently contracted to investigate suicides and homicides on these lands. During medicolegal death investigations, OMI collects demographic information and circumstantial information, as well as any relevant police reports, medical records, microbiologic test results, and toxicologic findings. Examination of the NMOMI database to identify characteristics of suicide associated with age, sex, and race between 1979 and 2005 has allowed us to create one of the largest population-based studies of young suicide decedents and identify patterns of suicide and suicidal behavior in this group.

Research Methods

Data Collection

The initial list of youth suicide cases was developed from an Access query of the NMOMI database for January 1979–November 2005, using in-house codes for manner of death and an age limitation of 17 years and younger. Demographic information and basic case information, including age, gender, race/ethnicity, county of residence and county of pronouncement of death, method of suicide, toxicology results (blood alcohol concentration, drugs of abuse, and general drugs), and a brief description of the circumstances, were downloaded electronically into an Excel spreadsheet.

Using this case listing, additional data were abstracted from review of the hard copies of each case, including how and where a child hanged himself, what type of firearm was involved, the anatomic location of the gunshot wound, and where the suicide occurred (in the family home, outside, near school). Data were also collected on the decedent's height and weight, to calculate body mass index (BMI). Investigators' logs, findings from any contact with relevant persons, content of any suicide notes, and any available medical records were reviewed for information regarding risk factors. Individual risk factors were coded as present (1) or absent (0), with each score of 1 contributing to the cumulative total of each subheading of risk factor. The classes of putative risk factors were gleaned from review of the suicide literature and are listed in Fig. 1.

Data Analysis

Data were cleaned in Microsoft Excel and analyzed with SAS software, version 9.1 (SAS Institute, Cary, NC). Descriptive statistics were generated for youth suicides as a whole, then broken down by age category, gender, race/ethnicity, method of suicide, and presence of risk factors as determined by examination of the numbers of cases in each category. Categorical variables of interest, including sex, race/ethnicity, BMI category (underweight, normal, risk of being overweight, overweight), presence/absence of a note, and method were compared using either chi-squared or Fisher exact tests to determine differences by gender, racial/ethnic classification, age category, and method of suicide. Differences in continuous variables, including age and numbers of risk factors, were analyzed using *t*-tests. *p*-Values of 0.05 or less were considered statistically significant.

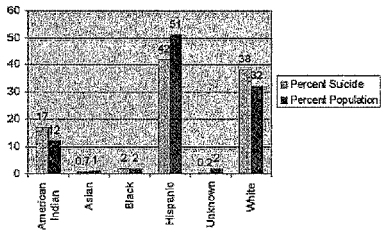

FIG. 1—*Ethnic groups, percent suicide versus percent population in New Mexico.*

Results

Demographics

A review of OMI's database identified 433 suicides meeting our case definition, with ages ranging from 9 to 17 (Table 1). The age-adjusted suicide rate was 4.8 per 100,000 with a male to female ratio of 3.8:1; in both males and females, suicide was more prevalent among older teens. Interestingly, rates continued to increase with age in males, while in females rates were highest at age 16 and then dropped at age 17. Non-Hispanic White people, American Indians, and males of all ethnic groups were over-represented among suicides, compared to the percentage of population they comprise (Figs. 1 and 2). Genders and ethnic groups did not differ significantly in age, and there was no significant change in gender, race, or age over time, although there was an increase in suicide deaths per year over the study period. Seventy-six percent of decedents killed themselves in their own homes or yards and 24% in some other location (including the home of a friend or relative, hotel or motel, open space, or forest land). Parental location is unknown for 48% of cases; 33% of parents were home at the time of suicide and 19% were away from home.

TABLE 1—*Demographic characteristics.*

	Male	Female	Total Number (Percent of Total)
Age (years)			
9	4	0	4 (0.9)
10	1	0	1 (0.2)
11	8	0	8 (1.9)
12	16	1	17 (3.9)
13	24	9	33 (7.6)
14	28	17	45 (10.4)
15	58	18	76 (17.6)
16	93	26	119 (27.5)
17	110	20	130 (30.0)
Ethnicity			
American Indian	61	11	72 (16.6)
Asian	1	2	3 (0.7)
Black	8	0	8 (1.9)
Hispanic	141	42	183 (42.3)
White	131	36	167 (38.6)

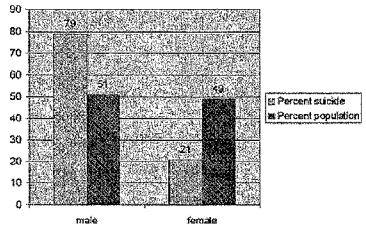

FIG. 2—*Gender, percent suicide versus percent population in New Mexico.*

Means

Gunshot wound was the most frequent method of suicide (58%), followed by hanging (30%), overdose (5%), carbon monoxide poisoning (2%), and other (5%, including poisoning, drowning, stabbing, jumping from height, and motor vehicle crash). There was a statistically significant association between age and method of suicide ($p = 0.0012$), with younger age associated with hanging and older age associated with firearm-related death. In addition, hanging deaths were significantly more common among American Indians than other ethnic groups ($p < 0.0001$). Over the study period, there was a statistically significant decrease in deaths by firearm and a concurrent significant increase in hanging deaths.

With regard to firearm-related deaths, a handgun was used in 55% of cases, rifle in 32%, and shotgun in 13%; 87% of decedents shot themselves in the head, 11% in the chest, and 2% in the abdomen. Among hanging deaths, the ligatures most often used were belts and ropes (each 32% of cases), and the most common suspension points were closet rods (25%), roof trusses (18%), trees (15%), and bunk bed frames (10%).

Predisposing Factors

Psychiatric problems were reported in 46% and denied in 9% of cases; mental health history was not mentioned in 45% of cases. Of those in whom psychiatric problems were reported, 51% were reported to be depressed, 17% to have substance abuse issues, 12% to have "behavior problems," 7% to have problems with impulse control or anger management, and 13% to suffer from other ailments including bipolar disorder, schizophrenia, post-traumatic stress disorder, or eating disorders. Only 15% of decedents were reported to be receiving mental health treatment, 17% were reported to not be under the care of a mental health practitioner, and in 68% of cases the treatment status is unknown. With regard to other predisposing factors, chronic family problems were identified in 24.2% of cases, a history of physical or sexual abuse in 7.6%, and a history of chronic medical problems in 2.1% (Table 2).

Comparing the prevalence of predisposing factors among the three largest racial/ethnic groups in New Mexico (White Hispanic, White non-Hispanic, and American Indian), we found a mention of psychiatric/psychologic problems in 45% of White Hispanics (hereafter referred to as Hispanics), 49% of White non-Hispanics (subsequently referred to as White people), and only 37% of American Indian decedents (Table 3). The prevalence of chronic family problems and physical or sexual abuse, as found from examination of medical examiner records, was comparable across the three major racial ethnic groups (Table 3).

TABLE 2—*Predisposing and proximal risk factors for suicide.*

Behavioral/psychologic issues (depression, ADD)
History of physical or sexual abuse
History of deliberate self-harm or parasuicidal acts (self-mutilation, previous attempts)
Acute family problems (fight with family member, disciplined at home)
Sex/romance issues (pregnancy, fight with significant other)
School issues (teased at school, poor grades)
Family/friend suicide
Recent community suicide or involvement in suicide pact (contagion)
Chronic family problems (domestic violence, parent substance abuse)
Legal problems or a history of anti-social behavior
History of medical problems
Other social stressors (recent or impending move)
Intoxication at time of suicide
Overweight by BMI

TABLE 3—*Prevalence of risk factors for suicide among the three largest racial/ethnic groups in New Mexico.*

Risk Factor	Hispanic *n* (%)	American Indian *n* (%)	White *n* (%)
Psychologic problems	82 (45)	27 (37)	82 (49)
Victim of abuse	10 (5)	5 (7)	10 (6)
Parasuicidal behavior	91 (50)	32 (44)	78 (47)
Acute family problems	52 (28)	23 (32)	55 (33)
Chronic family problems	37 (20)	15 (21)	43 (26)
Sex/romance issues	40 (22)	10 (14)	34 (20)
School problems	27 (15)	8 (11)	26 (16)
Contagion	5 (3)	3 (4)	5 (3)
Legal problems/anti-social	40 (22)	15 (21)	39 (23)
Medical problems	6 (3)	0	7 (4)
Intoxicated at time of suicide	53 (24)	22 (31)	31 (19)
Overweight by BMI	41 (28)	14 (32)	29 (21)
Other risk factors/stressors	19 (10)	14 (19)	18 (11)

Table 4 presents the prevalence of predisposing factors and proximal stressors among youth suicides in New Mexico by gender. The prevalence of psychologic problems was similar between boys and girls (46% and 53%, respectively), whereas 22% of girls and only 2% of boys reported being a victim of abuse. Girls also were more likely to have had a history of chronic family problems than boys (34% vs. 20%).

Proximal Stressors

Of the cases in which proximal stressors were reported, the most common acute stressors were fighting with parents and problems

TABLE 4—*Prevalence of risk factors for suicide among New Mexico youth by gender.*

Risk Factor	Males *n* (%)	Females *n* (%)
Psychologic problems	150 (46)	27 (53)
Victim of abuse	7 (2)	20 (22)
Parasuicide/self-harm	158 (46)	50 (55)
Acute family problems	106 (31)	28 (32)
Chronic family problems	69 (20)	31 (34)
Sex/romance issues	54 (16)	30 (33)
School problems	52 (15)	10 (11)
Contagion	11 (3)	2 (2)
Legal problems/anti-social	88 (26)	11 (22)
Medical problems	12 (4)	1 (1)
Intoxicated at time of suicide	99 (29)	11 (22)
Overweight by BMI	69 (26)	17 (25)
Other risk factors/stressors	43 (13)	9 (10)

with romantic partner, followed by legal problems, being disciplined at home or school, poor grades, household disruption (including recent death, parental separation or divorce, and recent or upcoming move), and pregnancy or feared pregnancy (Table 2). Ten percent of decedents had been suspended or expelled from school, 2% had dropped out of school, and 1% of decedents were incarcerated at the time of suicide. Another 5% had a history of "skipping" school due to conflicts with administrators, teachers, or fellow students. Eight percent had a history of violent behavior, including assault or homicide. Of note, <4% were noted to have a recent friend or family suicide or were involved in a suicide pact (Table 2).

The prevalence of many proximal stressors was similar across the three largest racial/ethnic groups in New Mexico (Table 3). Acute family problems were mentioned in the investigations of 28–33% of youth decedents by race/ethnicity, and school problems ranged from 11% among American Indians to 16% among White people. Issues with a romantic partner were reported by 22% of Hispanic decedents, 20% of White decedents, and only 14% of American Indian decedents. Girls had mention of problems with romantic partners in 33% of suicides, whereas boys' files mentioned sexual or romantic problems in only 16% of suicides (Table 4).

Parasuicidal and Peri-Suicidal Behavior

Twenty-eight percent of decedents were known to have previous suicidal gestures or suicide attempts (parasuicidal behavior). This was the most commonly found risk factor for both Hispanic and American Indian youth suicides (Table 3), and the second most commonly reported risk factor among White decedents. Boys and girls both had a high prevalence of reported parasuicidal behavior (Table 4).

Twenty percent of decedents were reported to have told someone about their plans to commit suicide; in 19% of cases, talk of suicide was denied, and in 53% of cases there was no information in the file with regard to this history. Twenty-five percent of decedents left a suicide note; females were three times more likely to leave a note ($p < 0.0001$), but note-leavers did not otherwise differ significantly by age, ethnicity, method of suicide, or the presence of alcohol or other drugs. The most common themes for suicide notes were "suicide is the only solution for my problems" (26%) and "life is too much to bear" (24%). Other note themes included instructions for disposition of goods, apologizing for actions, and expression of anger at someone, usually a parent or step-parent.

Physical Findings

At autopsy, 21% of decedents had scarring consistent with self-mutilation or "cutting" behavior. Only 13% were overweight and 13% at risk for overweight according to Centers for Disease Control and Prevention (CDC) growth charts. Sixty-nine percent were of normal weight, and 5% were underweight. American Indian youth suicides had a higher prevalence of overweight, with 32% either being overweight by BMI (kg/m^2) or at risk for being overweight (Table 3), compared to 28% of Hispanic decedents in this study and 21% of White decedents. Girls and boys had similar prevalence of being overweight or at risk of being overweight by BMI (25% and 26%, respectively; Table 4). This number is very similar to that for all high school students in New Mexico, where 24% of the students are either overweight or at risk for being overweight (13).

Toxicology testing was more often positive in decedents over the age of 15 and only rarely positive in decedents younger than 15. Alcohol was present in 20% of cases; males were 2.7 times more likely to have alcohol present than females. American Indians and Hispanics were more likely to be intoxicated at the time of suicide than White people (1.9 times and 1.5 times, respectively), and those who shot themselves were 2.4 times more likely to have alcohol present than those who hanged themselves or used other methods. Boys were more commonly intoxicated at the time of suicide than were girls (29% and 22%, respectively; Table 4). Other prescription and illicit drugs were present in 6% of cases; of note, <5% of decedents had detectable levels of any psychiatric drug. Illicit drugs detected included marijuana (4%), cocaine (1%), volatile inhalants (1%), and heroin, LSD, and peyote (each <1%).

Discussion

Overall, we found that the rate of suicide is consistently higher in New Mexico than nationally. As noted above, White people, American Indians, and males of all ethnic groups are over-represented among suicides, compared to the percentage of population they comprise in New Mexico. This is consistent with other studies showing higher suicide death rates in western states and in these population subgroups (9–11). The male to female ratio in this study was 3.8:1, also consistent with previous studies showing that males of all ages in the United States are three to four times more likely to take their own lives than females (9–11).

As seen in most studies, firearms were used by a majority of adolescents in this study. However, among younger individuals and Native Americans, the preferred method was hanging. Furthermore, although there was a decrease in gun-related suicides over the study period, there was a concurrent rise in hanging deaths, suggesting that method substitution may interfere with means restriction. The private nature of hanging and the widespread availability of implements for hanging make means restriction less practical for this method than for the use of guns. These factors also make hanging more appealing to youth with limited access to guns or other weapons.

When discussing the prevalence of risk factors in this study, it is important to note that although the scene guidelines used by OMI investigators in youth suicides were designed to gather as much relevant information as possible during the course of an investigation, some questions may be omitted or not answered during a youth suicide investigation. Additionally, other risk factors (such as childhood exposure to domestic violence, or physical and sexual abuse) may not be routinely reported to investigators. No additional interviews were conducted to verify collected information or obtain more information; therefore the prevalence of risk factors may be underestimated in this study. It is also possible that some suicides on federal lands were not investigated by OMI, as OMI can only investigate on federal lands by invitation.

With regard to predisposing factors for suicide, chronic family problems, including physical or sexual abuse, domestic violence in the home, parental substance abuse or mental health problems, and breakup of the family or banishment from the home, were reported in more than 30% of cases. Ongoing psychiatric issues were reported in nearly half of the cases. Psychiatric illnesses appear to be inadequately treated in this population, with only 15% reported to be receiving mental health care and <5% having detectable levels of psychiatric drugs at the time of suicide. While these numbers are low, previous studies have reported that as few as 1% of youth suicide completers were in mental health treatment at the time of

suicide (12). It is not clear whether this is due to lack of compliance, lack of resources, or both.

Of the top 10 reported proximal stressors, most were subacute or chronic problems; even the seemingly acute (fight with parent, breakup with significant other, disciplined at home, fight with sibling) could be exacerbations of chronic problems. This trend suggests that suicide is a response to long-term difficulty in conflict resolution and problem-solving, rather than an impulsive act triggered by an isolated stressful event.

Comparing the prevalence of predisposing factors and proximal stressors between the three largest racial/ethnic populations in New Mexico, we found more similarities than differences. Psychologic and psychiatric problems were commonly found among Hispanic, White, and Native American decedents, as were previous suicidal gestures and self-harm. A history of both recent and more chronic family problems was noted in one-fifth to one-third of all suicides in all three racial/ethnic categories. In all three racial/ethnic groups, contagion and medical problems were rarely mentioned as having contributed to the suicide. Gender differences in risk factor prevalence were more marked than racial/ethnic differences, with girls more commonly having had a reported history of psychologic problems, personal abuse, issues with a romantic partner, and chronic family problems than boys. These differences in risk factors by sex may aid in tailoring appropriate intervention strategies for both boys and girls.

Although alcohol or illicit drug use is frequently cited as a risk factor for suicide, there was a low prevalence of intoxication in this study, again suggesting that, in this population, suicide is more than an impulse. One-quarter of decedents left a suicide note; this is within the range reported in previous studies (4–40%). The leaving of a note in itself suggests some forethought; additionally, these notes almost uniformly reveal chronic hopelessness and a sense of pessimism about the future and the decedent's ability to cope with it. The use of suicide as a way of solving a chronic problem rather than an impulsive response to stress means that prevention programs based on impulse control, such as crisis intervention, will be less effective in this population.

Three-quarters of decedents killed themselves in their own homes or yards; in one-third of the cases, at least one parent was at home. Other studies report suicides at home ranging from 41% to 88% of the time (9–11), without information regarding the whereabouts of parents. Although suicide prevention literature suggests that parents play a vital role in suicide risk assessment (3,6), this does not seem to be the case in the study population. Moreover, given the prevalence of chronic family problems in this population, family-based risk assessment programs will not be effective in a substantial number of cases. It is also notable that *c.* 20% of the decedents were temporarily or permanently out of school at the time of suicide, suggesting that school-based prevention programs will miss a large group of suicidal youth.

Conclusions

The data from this study suggest that youth suicide in New Mexico is an attempt at problem-solving, characterized by chronic hopelessness rather than impulsivity, and determination rather than ambiguity; this is at variance with conclusions drawn in other studies. The benefit of current secondary and tertiary prevention programs (focused as they are on crisis intervention and means restriction) is not demonstrated. In the face of chronic problems and long-standing hopelessness, crisis intervention may be too little, too late. As noted, controlling access to lethal means can be circumvented by method substitution (i.e., hanging for shooting) or by using implements that are difficult to control (i.e., using a sweatshirt to hang oneself from a bunk bed). Lastly, the delivery of current prevention programs (through awareness and peer-counseling programs in schools) may not be reaching the target audience; many at-risk youths are alienated from community, family, and peers and are out of school either temporarily or permanently by the time they come to suicide.

Thus the need for primary prevention programs seems clear. These programs, instead of focusing on late-stage prevention such as crisis intervention, would address underlying risk factors for suicide: mental health, social competence, conflict resolution, problem-solving, and family/community support. Pessimism about the future may be tied to the individual's social environment and life experiences, and exposure to social factors, such as poverty, unemployment, prejudice, and discrimination, may differ for various ethnic groups and/or genders. Although this study suggests that predisposing factors and proximal stressors differ more by gender than by ethnic group, further research is needed to examine adolescent subgroups (younger vs. older, male vs. female, White vs. Hispanic vs. Native American) and to compare suicide attempters with suicide completers, to develop alternative risk-profiling and intervention strategies that are robust enough to account for social and cultural differences. To achieve this, we are currently working to compile a comparison group of young people who have attempted but not completed suicide, to allow analysis of both demographic and risk factor differences between these two groups. Intervention strategies tailored specifically to children and adolescents are more likely to be acceptable to, and effective in, this important and vulnerable population.

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Suicide Death Rates per 100,000
United States and North Dakota

	1999	2000	2001	2002	2003	2004	2005	2006	2007
United States	10.5	10.4	10.7	11.0	10.8	11.1	11.0	-	-
North Dakota	11.6	10.0	12.1	13.7	12.8	11.4	14.5	14.3	14.5

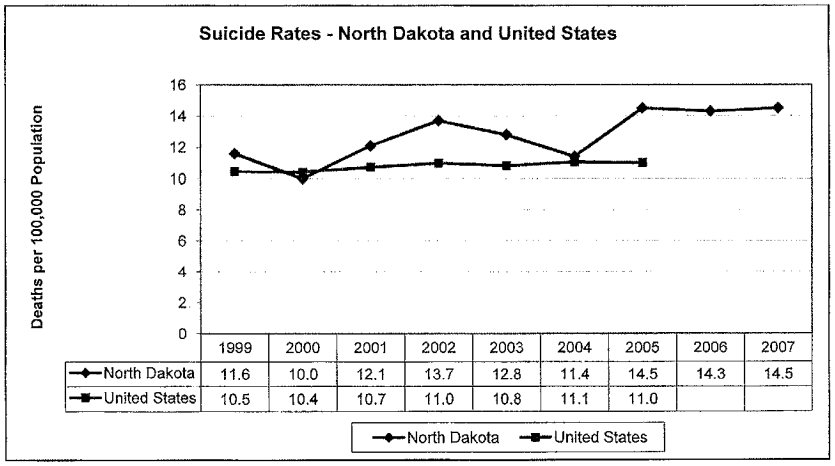
U.S. Source: WISQARS™ (Web-based Injury Statistics Query and Reporting System)

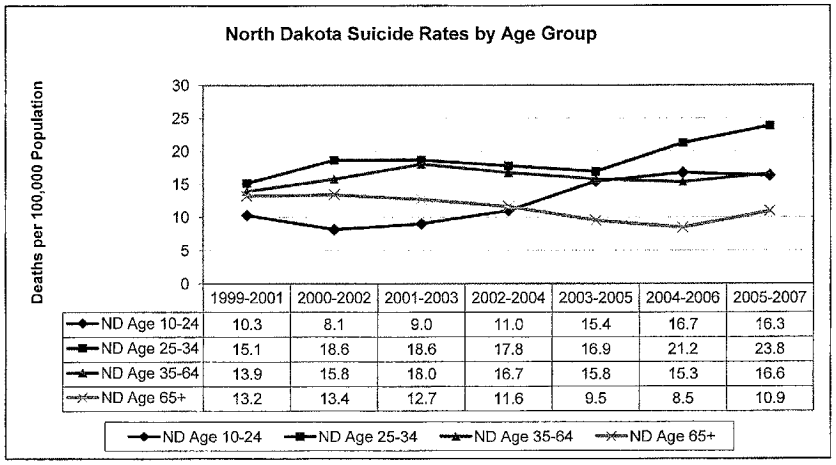
ND Source: North Dakota Vital Records

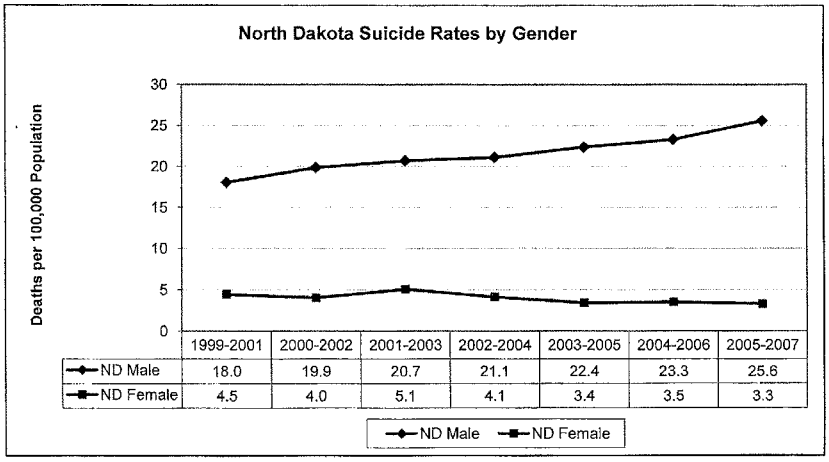
Suicide Death Rates per 100,000
North Dakota by Age, Gender and Race

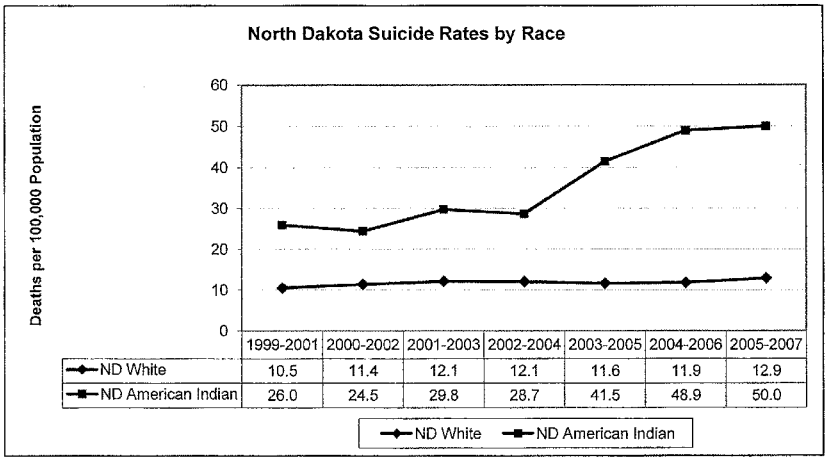
	1999-2001	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007
ND Age 10-24	10.3	8.1	9.0	11.0	15.4	16.7	16.3
ND Age 25-34	15.1	18.6	18.6	17.8	16.9	21.2	23.8
ND Age 35-64	13.9	15.8	18.0	16.7	15.8	15.3	16.6
ND Age 65+	13.2	13.4	12.7	11.6	9.5	8.5	10.9
ND Male	18.0	19.9	20.7	21.1	22.4	23.3	25.6
ND Female	4.5	4.0	5.1	4.1	3.4	3.5	3.3
ND White	10.5	11.4	12.1	12.1	11.6	11.9	12.9
ND American Indian	26.0	24.5	29.8	28.7	41.5	48.9	50.0

Source: North Dakota Vital Records


Suicide Rates - North Dakota and United States
Deaths per 100,000 Population
16
14
12
10
8
6
4
2
0
1999 2000 2001 2002 2003 2004 2005 2006 2007
North Dakota 11.6 10.0 12.1 13.7 12.8 11.4 14.5 14.3 14.5
United States 10.5 10.4 10.7 11.0 10.8 11.1 11.0
North Dakota
United States


North Dakota Suicide Rates by Age Group
Deaths per 100,000 Population
30
25
20
15
10
5
0
1999-2001 2000-2002 2001-2003 2002-2004 2003-2005 2004-2006 2005-2007
ND Age 10-24 10.3 8.1 9.0 11.0 15.4 16.7 16.3
ND Age 25-34 15.1 18.6 18.6 17.8 16.9 21.2 23.8
ND Age 35-64 13.9 15.8 18.0 16.7 15.8 15.3 16.6
ND Age 65+ 13.2 13.4 12.7 11.6 9.5 8.5 10.9
ND Age 10-24
ND Age 25-34
ND Age 35-64
ND Age 65+


North Dakota Suicide Rates by Gender
Deaths per 100,000 Population
30
25
20
15
10
5
0
1999-2001 2000-2002 2001-2003 2002-2004 2003-2005 2004-2006 2005-2007
ND Male 18.0 19.9 20.7 21.1 22.4 23.3 25.6
ND Female 4.5 4.0 5.1 4.1 3.4 3.5 3.3
ND Male
ND Female


North Dakota Suicide Rates by Race
Deaths per 100,000 Population
60
50
40
30
20
10
0
1999-2001 2000-2002 2001-2003 2002-2004 2003-2005 2004-2006 2005-2007
ND White 10.5 11.4 12.1 12.1 11.6 11.9 12.9
ND American Indian 26.0 24.5 29.8 28.7 41.5 48.9 50.0
ND White
ND American Indian

Nadine Tafoya and Associates
Ann Del Vecchio, Ph.D.
May 21, 2008
Value Options / Albuquerque

Native American Prevention Initiatives in New Mexico funded through NM / DOH/OSAP/VO

Prevention Background

- Work Force Development in New Mexico
- Prevention Generalist Training (PGT)
- Substance Abuse Prevention Training (SAPT)

Introduction

- Brief history
  - 1997 NM DOH/ BHSD received first state incentive grant (SIG)
    - State contracted with Tafoya and Associates to provide assistance to Tribes to ensure equity in accessing this new source of prevention funding
    - Tafoya and Associates developed a manual, *Developing Substance Abuse Prevention Programs in New Mexico's Native American Communities*
    - The Native American Prevention Steering Committee also was developed to provide the Sate with information about Tribal needs and capacity

Introduction continued

- The Manual was used to develop capacity in Tribal communities and organizations for the next 10 years
- The Steering Committee has provided the State with information and feedback on Tribal needs, issues, concerns, and strengths
- Approximately 6 programs have been funded annually to Tribes and Tribal organizations around the state.
- More than 10% of Native youth in NM receive prevention services.

Overview

- Currently NM/DOH/OSAP/VO funds
  - Direct Service:
    - Isleta Pueblo
    - Five Sandoval Indian Pueblos, Inc.
    - Mescalero Prevention Program;
    - National Indian Youth Leadership Project;
  - Strategic Prevention Framework Environmental strategies:
    - Laguna Pueblo
    - Mescalero Prevention Program
    - McKinley County

Direct Service Programs

- A variety of models are used including:
  - Botvin's Life Skills Training
  - Project Venture
  - Dare To Be You

- Outcomes include:
  - Decreases in risk factors (fights and violence, alcohol, tobacco, and other drug use;
  - Increases in protective factors (improved school attendance, grades, communication with families and friends)

- A five step community mobilization model that focuses on developing environmental strategies (to change norms, laws, policies that affect substance use). The SPF focuses on underage drinking and drinking and driving in NM and works toward changes in the following areas:
  - Retail Access
  - Low law Enforcement
  - Social Access
  - Social and Community Norms
  - Low Perception of Risk

- Strategies and accomplishments include:
  - Coordination of law enforcement agencies across multiple jurisdictions (state, county, city, Tribal, federal).
  - Change in Tribal policy to report on reservation DWI arrests to the NM Motor Vehicles Department and Traffic Safety Bureau
  - Comprehensive awareness campaigns to increase awareness of law enforcement and the perception of risk

Suicide Prevention

- SPF process to identify needs, capacity, strategies
  - Research based model used at Jicarilla included community mobilization, community assessment and capacity assessment, identification of evidence based models for prevention and intervention, comprehensive, coordinated community based response
  - Isleta
    - Community Action Team
  - Mescalero
    - Mescalero Region Community Prevention Coalition

Accomplishments

- Over a decade of planning, materials development, ongoing two way work with the Tribes and the State has resulted in:

1. Capacity development to do evidence based prevention planning and program support in all 222 Tribes and urban Native organizations in the state;
2. Increased awareness among Tribal leaders for evidence based prevention programs;
3. Increased protective factors and decreased risk factors among Native youth involved in prevention programs

Statewide change

- Within the past ten years there have been major changes that have taken place which have greatly improved tribal-state relations such as:
  - The Office of Indian Affairs elevated from a division to a department;
  - Tribal Liaison positions have been created in most state departments;
  - An increase in Native American appointments from the Governor's office for key leadership positions in state government;
  - The development of an Office of Indian Health at the Department of Health.

Conclusion

- Raised the awareness among state agencies / staff of unique needs and concerns about prevention in Native communities.
- Raised Tribal awareness and understanding of the need for evidence based prevention programs.
- Leveled the playing field for planning and implementing evidence based prevention among the Tribes by providing training and capacity development.
- Provided direct service programs to approximately 20,000 Native youth since 1997.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. BYRON L. DORGAN TO HON. ROBERT G. MCSWAIN

1. **Youth Suicide Response:** You mentioned in your testimony that in 2003, IHS began the suicide initiative. The initiative includes: IHS Suicide Prevention Committee (SPC), a working group, website, annual conference and other efforts. Also IHS now has an Emergency Medical Services and Preparedness Division which supports Indian communities by implementing the IHS Emergency Response to Suicide Model during a rise in incidence of suicide in an Indian community. The goal is to assess the community and coordinate a response to stabilize the community.

   - **What is the level, or number of suicides, that IHS implements the Emergency Response Model?**

     Communities are encouraged to take advantage of local and regional response resources and capacity for any suicides or suicide-related events. When such capacity and resources appear to be exceeded, a native community or a provider serving that community and observing a trend in attempted or completed suicides that signify the possibility of further related suicide events may request for additional help from the U.S. Public Health Service through IHS and the Office of Force Readiness and Deployment. IHS uses the Emergency Suicide Response Model (ERSM) to organize the response to the requesting community.

   - **Explain what the Emergency Response Model involves.**

     When an individual or community experiences a crisis or traumatic event such as an individual attempting or completing suicide, the entire community is affected. Therefore, the IHS Emergency Response Model design responds both to the individual(s) in crisis and the community affected. This new Model is designed to assist American Indian or Alaska Native (AI/AN) communities in mitigating the immediate crisis, and stabilizing the community so that long-term solutions (planning, prevention, and implementation plans) can be developed by the community.

     To request U.S. Public Health Service (USPHS) assistance for suicide events in AI/AN communities, the following steps are recommended:
     - An AI/AN community requests help for suicide events through the IHS Service Unit, Tribal health program, or urban Indian clinic to the IHS Area Office.
     - The Area Director then makes the request for assistance to IHS Headquarters (HQ) Division of Behavioral Health (DBH) Director who notifies the appropriate IHS HQ staff.
     - IHS DBH and Emergency Services (ES) staff responds to the affected community and conducts a rapid needs assessment. While on site, HQ staff

will meet with critical staff from the IHS Area Office, Tribal health program, urban Indian clinic, IHS Chief Executive Officer, the Tribal Council, and other Tribal programs as requested.

Contingent on the rapid needs assessment and the expressed needs of the community, a request from the IHS ES Director will be put forward to the USPHS Office of Force Readiness and Deployment. The request will be USPHS mental health providers in teams of two or more that can be mobilized to deploy for two week rotations to provide emergency mental health and community outreach services for up to 90 days.

- **Since IHS began actively using this model, has there been a decrease in the number of youth suicides or the prevention of suicide clusters in Indian Country?**

  Yes, in the two out of the three communities where the Model was fully utilized, there was a reduction for the Tribal community.

- **There must be a first youth suicide which triggers a suicide cluster, so does IHS respond to a single suicide to prevent a cluster?**

  Single youth suicides are major events in most AI/AN communities and typically generate significant system-wide reviews and responses. Youth suicides frequently come to the healthcare system's attention through community agencies such as the police department and schools. Initial responses are almost always coordinated and managed by the system of care at the community level. These systems include but are not limited to IHS. Communities vary dramatically across Indian Country in their local capacity to adequately intervene and manage events. Thus, there may be times when IHS is the first and primary responder to such events, but more often IHS joins with a larger community response group. IHS providers frequently coordinate closely with local systems (e.g. Fort Defiance IHS led the response to a recent suicide outbreak on the Navajo Nation in coordination with a variety of agencies and the Tribe) to respond to the event and prevent additional suicide attempts or completions.

- **What is the single biggest barrier IHS faces in addressing youth suicide?**

  The biggest barrier remains the dilemma that youth suicide is likely driven by factors far beyond those typically addressed in healthcare. Successful suicide reduction efforts are systemic in nature and require attention to community social systems including parenting and early childhood support to establish robust support networks. There are factors that place AI/ANs at risk for suicide including risk factors that place any individual at risk (e.g. mental illness and substance abuse) and factors that are unique to AI/ANs. Risk factors affect multiple generations of AI/ANs. IHS also works to provide prevention activities such as school-based life skills programming, clinical interventions, and support for Tribal sovereignty and self-determination. Based on studies from researchers at the University of British Columbia, there was clear evidence that "First Nations communities that succeed in taking steps to

preserve their heritage culture and work to control their own destinies are dramatically more successful in insulating their youth against the risk of suicide."[1] The Canadian researchers found that cultural continuity could be promoted by a Tribe's control over such things as its education, public safety, and health delivery services. Cultural continuity is the extent to which the language, traditions, values, and practices of a culture have continued over time and are likely to continue into the future. Indigenous language is also a strong marker of cultural persistence and is a strong predictor of health and well-being. Safer and healthier communities with better social support should over time contribute to lowering of suicide rates and behavior.

2. **Research and Data Collection in Indian Country:** We discussed the difficulty of data collection and the variation in rates of youth suicide across Indian Country. The data for youth suicide in Indian Country is not consistent across sources.

   - **How do the Tribal Epidemiology Centers submit their data and where is it available?**

     The Tribal Epidemiology Centers (TEC) do not provide data to IHS on suicide. Because the TEC's are operated from within Tribal organizations, their data collection and analysis activities are determined by Tribes, rather than directed by IHS. TEC's are not required to submit data to IHS or DHHS on suicides. If a Tribe operating a TEC requests that the TEC work on suicide, any data and/or reports would be submitted by the TEC directly back to the requesting Tribe. The TEC's would require Tribal approval in order to release the results of such work.

   - **Is the ultimate goal of the "data mart" you mentioned to predict and plan the need for prevention programs?**

     Yes. When implemented, the data mart will report on multiple demographic, treatment, and activity parameters. These data are currently exported electronically from the local treating site to a national data base, and are currently being used to help identify locations and types of suicidal events, redistribute clinical resources as needed, and develop suicide prevention activities based upon data contained in the data mart. These activities will enhance the national deployment scheduled for late 2009.

     Not all IHS programs/Tribes use this electronic method of data collection, but it is increasingly being used across our Indian health system with over 350 sites currently reporting. Implementation of the data mart will allow the agency to obtain a more complete picture of suicidal events throughout Indian Country and more accurately identify cluster events.

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[1] Chandler, M.J., & LaLonde, C. (1998). Cultural continuity as a hedge against suicide in Canada's First Nations. *Transcultural Psychiatry, 35,* 191 – 219. Available online at http://web.uvic.ca/~lalonde/manuscripts/1998TransCultural.pdf.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. JOHN BARRASSO TO HON. ROBERT G. MCSWAIN

1. The former Director of the Indian Health Service (IHS), Dr. Charles Grim, testified before this Committee in 2005 that a primary objective the IHS was working on relative to youth suicide was expanding and enriching the data research around Indian Country, not only for the risk factors, but also the protective factors, to determine why some tribal communities do not have this problem while others do.

   - **Why do some Tribal communities have this problem while others do not?**

     Social and familial disruption, cultural conflict, and social disorganization are often cited as major influences on American Indian suicide rates.[2] Suicide rates among American Indians vary with the degree of social and cultural change and acculturation pressure. The high suicide rates among youth in Indian families and communities have been attributed to acute acculturation stress, cultural conflict, and social disorganization. The acculturative stress increases the risk of alcohol or drug abuse, depression or other mental disorders, and suicidal behavior.

   - **What is IHS doing about suicide?**

     On February 7 – 9, 2006, the Indigenous Suicide Prevention Conference was sponsored by the Indian Health Service, Division of Behavioral Health in Albuquerque, New Mexico. The Indian Health Service (IHS), the National Institutes of Health (National Institute of Mental Health, Office of Rare Diseases, National Institute on Drug Abuse, National Institute on Alcohol Abuse and Alcoholism, National Library of Medicine) joined with the Substance Abuse and Mental Health Services Administration, to host participants from the US, Canada, and the US Territories to attend the first ever meeting for reducing suicide among Indigenous communities. The Indigenous Suicide Prevention Conference was the first ever international gathering of Indigenous researchers, service workers, community programs, and government representatives from across Canada, the US, and US Territories. This conference sought to illuminate the current state of knowledge of suicide across Indigenous people and to foster collaboration for addressing suicide prevention.

     There are several suicide prevention activities throughout IHS. There are IHS Areas that have suicide prevention strategic plans, suicide prevention task forces, and suicide prevention training has been provided. For example, the Navajo Nation Department of Health and Indian Health Service will develop a Six-Point strategy to address suicide and promote a multifaceted and comprehensive public health approach to suicide prevention. The plan is to implement a Navajo perspective to suicide prevention including the belief that "Life is Sacred" and the philosophy of

[2] Institute of Medicine (2002). *Reducing suicide: A national imperative.* Goldsmith, S.K., Pellmar, T.C., Kleinman, A.M., & Bunney, W.E. (Eds.) Washington, DC: National Academies Press.

"Walking in Beauty." The IHS Aberdeen Area continues to move forward with providing trainings on QPR (Question, Persuade, and Refer), ASIST (Applied Suicide Intervention Skills Training), and Mental Health First Aid. They have a summer schedule for providing the trainings to various reservations. These are just a few examples of the IHS suicide prevention efforts.

- **What has IHS found out about suicide?**

We know that there are a wide range of general risk factors that have been shown to contribute to suicide in all adolescents, regardless of their cultural background. However, in the case of AI/AN young people, we can argue that they face, on average, a greater number of these risk factors at once or that the risk factors are more severe in nature. In addition, AI/AN youth often face additional risks that arise, at least in part, from being members of a historically marginalized and economically disadvantaged group. Having a thorough understanding of the specific risks as well as protective factors that are relevant to AI/AN youth is important when we plan for suicide prevention. Increasing protective factors is equally or more effective than decreasing risk factors in terms of reducing suicidal risk. Research suggests that one of the strongest factors that protect Native youth and young adults against suicidal behavior is their sense of belonging to their culture. Culturally sensitive programs that strengthen family ties can help protect AI/AN adolescents against suicide. Various studies also suggest other culturally based protective factors such as a strong tribal spiritual orientation. When a suicide has occurred, suicide risk seems to be decreased by a healing process that involves the role of elders and youth in decision making, the presence of adult role models, and the use of traditional healing practices. AI/AN people have continued to show remarkable resiliency in their ability to survive, and in many cases thrive, despite the impact of historical trauma. Historical trauma includes forced relocation, the removal of Indian children who were sent to boarding schools, the prohibition of the practice of language and cultural traditions, and the outlawing of traditional religious practices. IHS supports the development of locally-driven initiatives that aim to lessen the impact of risk factors while enhancing those factors that are known to protect against suicide. Since we know that no one single solution exists, we must work towards developing a comprehensive approach to preventing youth suicide and suicidal behavior that incorporates these key factors in the most efficient, coordinated, and systematic manner possible.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. MARIA CANTWELL TO HON. ROBERT G. MCSWAIN

1. **While your agencies have had some success with programs such as Native Aspirations, which was developed in my home state, how are your two agencies working together to combat youth suicide and the linked issue of drug addiction? It is important that your two agencies along with the Department of Justice work hand in hand to combat these serious issues.**

According to the Institute of Medicine, an estimated 90 percent of individuals who die by suicide have a mental illness, a substance abuse disorder, or both.[3] A growing body of studies demonstrates that alcohol and drug abuse are second only to depression and other mood disorders as the most frequent risk factors for suicide. Some risk factors such as substance abuse are more prevalent among AI/AN youth and may be contributing significantly to their higher suicide rate. For example, AI/AN youth aged 12 to 17 have the highest rate of drinking of all racial/ethnic groups. Given the significant relationship between suicide and both substance abuse and mental disorders, IHS recognizes that suicide is preventable and requires collaboration with partners such as the Department of Justice.

IHS collaborates with Tribes and Tribal organizations, Urban Indian programs, Federal (e.g. SAMHSA, CDC, NIMH), State, and local agencies, as well as public and private organizations (e.g. Suicide Prevention Resource Center, National Suicide Prevention Lifeline) to formulate long term strategic approaches to address the issue of suicide in Indian Country more effectively. For example, suicide prevention programming was offered at the IHS/SAMHSA National Behavioral Health Conference on August 20-22, 2008 in Billings, Montana. The conference was held in conjunction with the Tribal Justice & Safety Tribal Consultation, Training & Technical Assistance Conference that was held on August 19-22, 2008 in partnership with SAMHSA, the Department of Justice, and the Bureau of Indian Affairs. This partnership continues with this year's Tribal Justice and Safety Conference.

Preventing suicide and suicidal behavior requires the support and contributions of many partners: Federal agencies, state and local health departments, nonprofit organizations, academic institutions, international agencies, and private industry. IHS collaborates regularly with these groups as evidenced by the Surgeon General's National Strategy to Prevent Suicide. In 2001, the U.S. Department of Health and Human Services issued the National Strategy for Suicide Prevention. The Office of the Surgeon General coordinated the efforts of numerous agencies, including IHS, SAMHSA, CDC, NIMH, HRSA, and other public and private partners to develop the first, comprehensive, integrated, public health approach to reducing deaths by suicide and suicide attempts in the United States. IHS plays a key role in the Federal Steering Group for the National Strategy for Suicide Prevention. This Group provides recommendations and guidance for implementing the National Strategy; coordinates Federal initiatives to prevent suicide; and collaborates with federal and non-Federal partners to advance Strategy goals and objectives.

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[3] Ibid.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. TOM COBURN TO HON. ROBERT G. MCSWAIN

1. **When citing statistics comparing Native American suicide rates with the general population, does the data differentiate between reservation based and non-reservation based tribes and tribal members?**

   No, the IHS data does not differentiate between reservation based and non-reservation based tribes and tribal members. The IHS mortality suicide rates are based upon 3 years combined of mortality data for the IHS service area or the 12 IHS service areas. The IHS service area represents "on or near" reservations and is defined by the Contract Health Service Delivery Area "counties" for the Tribes. The data are for American Indians or Alaska Natives, not by tribal members, and may include American Indians and Alaska Natives who are not eligible for IHS services. IHS uses the mortality data received from the National Center for Health Statistics edited to reflect the IHS service area.

Response to the following written questions was not available at the time this hearing went to press

WRITTEN QUESTIONS SUBMITTED TO HON. ROBERT MOORE

Questions from Senator Dorgan:

1. It is heartbreaking to learn that already this year your tribal community has suffered one suicide and more than a dozen suicide attempts.
   - Can you describe what steps have been taken this year to prevent another suicide epidemic?

2. In your testimony, you talked about the despair that many of your young people live in: witnessing the emotional and social impact of poverty, abusive households, watching other young people take their own lives, and the high rates of infant deaths within your community. All of these social problems seem to be embedded in some of our tribal communities. It seems to me that these factors would tremendously impact a youth growing up in this environment.
   - Are there any programs within your community that specifically address early childhood trauma?

3. In your testimony, you described about a half dozen programs that are currently in existence within the tribal community to address suicide prevention.
   - How long have these programs been in existence? Have you seen any positive impacts from the programs? Where does funding for the programs come from?

Question from Senator Barrasso

4. In 2005 on this same topic, Indian youth suicide, former Surgeon General Richard Carmona testified before the Committee that there had to be scientific scrutiny applied to the cultural variables before they can be addressed and programs developed that would include those variables in suicide prevention.

   How would you suggest such cultural aspects be included and evaluated in suicide prevention programs?

WRITTEN QUESTIONS SUBMITTED TO R. DALE WALKER, M.D.

Questions from Senator Dorgan:

1. ***Suicide Prevention Guide*:** You mentioned in your testimony that the One Sky Center recently produced a *Suicide Prevention Guide* with funding from the Substance Abuse and Mental Health Services Administration's Center for Mental Health Services.
   - How do you plan to disseminate this guide throughout Indian Country?

2. **Research and Data Collection:** You mentioned that Indian Country lacks universal evaluations of suicide prevention and treatment programs, especially in regard to Culture-Based Interventions.
   - Do you feel that the Indian Health Service (IHS) Tribal Epidemiology Centers in the IHS Areas could provide a vehicle to better collect data and evaluate existing suicide prevention programs?

Questions from Senator Barrasso

1. In your written testimony, you noted that education and training shortcomings and other factors had left a fractured approach to suicide prevention, with duplication and unnecessary gaps. Your recommendation was to create a task force to implement and monitor the federal response to suicide.

   What would you recommend for eliminating duplication, gaps, and other shortcomings that may exist at the local levels for suicide prevention programs and responses?

2. In your written testimony, you recommended innovative research on Culture-Based Interventions and a strong policy commitment to ongoing evaluation of all prevention and treatment services together with utilization of that evaluation in program improvement.

   What has been available from SAMHSA and the Indian Health Service for research into culturally-based interventions and program evaluations?

Questions from Senator Cantwell:

1. The rate of suicide among Native American youth in Washington State is more than double the rate of non-Natives. I know that the Northwest Portland Area Indian Health board has just published a handbook on suicide prevention for tribes in the Pacific Northwest; and at least a couple tribes have been utilizing your Native Hope for Youth and Applied Suicide Intervention Skills Training (ASIST) programs to reduce the youth suicide rate. What do you think Congress can do to assist the One Sky Center to reduce the suicide rate in the Northwest?

2. Research suggests that when developing programs to prevent suicide among American Indian and Alaska Native youth it is more advantageous to promote protective factors (like positive self-image, interpersonal communication skills, positive family dynamics, improved academic performance, and tribal connectedness), than it is to eliminate negative risk factors.

   Does this resonate with your experience, and what more should be done by state and national programs to help American Indian and Native Alaskan communities foster these protective factors among their teens and young adults?

WRITTEN QUESTIONS SUBMITTED TO HAYES A. LEWIS

Questions from Senator Dorgan:

1. Incidence of Youth Suicide in Zuni Population: You stressed in your testimony the need for continued suicide prevention programs in Indian Country. Suicide prevention efforts, like the Zuni Life Skills Development Program, correlated with a decline and ultimately an absence of suicide incidences in your community.

- When were the suicide prevention programs ceased in your community and how long after did you see repercussions of the lack in programming?

2. Youth Suicide Program Development: The Zuni Life Skills Development Program was developed with the advisement of experts like Dr. LaFromboise, who also testified at the hearing. You stated this program included curriculum for the schools and other programs for the Zuni youth.

- Procedurally, how did the Zuni Tribe come together to develop this suicide prevention program?

3. Role of Schools in Suicide Prevention: In your testimony, you mentioned curriculum on suicide prevention which has been included in schools in New Mexico and other areas. You also mentioned that much of the Native American youth in your area attend off-reservation public schools.

- Have you seen different rates of suicide in Native American youth who attend off-reservation schools as compared to schools on reservations?
- Are cultural-based initiatives for Native American youth available only in the school curriculum?

Questions from Senator Udall

4. Could you detail how the Zuni Life Skills Development Program (ZLSDP) specifically addressed identification and referral procedures for at-risk youth?

5. In regard to the recurrence of youth suicides in the Zuni community after a 15 year hiatus, you mentioned that the "warning signs in the community" had been evident for a number of years. Can you expand on this comment and its significance to local communities?

6. Many of our witnesses have stressed the importance of creating an open dialogue about suicide prevention amongst tribal communities. In your opinion, what was the driving factor that made the Zuni program successful in encouraging parents, students, and tribal leaders to engage in this kind of dialogue?

7. You mentioned that the ZLSDP was terminated due to a lack of community concern and tribal leadership. However, can you comment on the funding stream for this unique program? Was it predominantly tribally supported or did you receive state and federal financing as well?

8. Many of our witnesses have cited using culturally-based approaches as being the most effective in youth suicide prevention. Moreover, Dr. Walker cited the need to increase research on culture-based interventions. In your experience, what kind of culturally-based approaches were most successful at preventing youth suicide and galvanizing community support and awareness on this issue?

WRITTEN QUESTIONS SUBMITTED TO TERESA D. LAFROMBOISE, PH.D.

1. There have been several recommendations from this and prior hearings to develop community-based suicide prevention programs which should include schools.

The American Indian Life Skills Development curriculum that you had developed appears to be directed at high school children, but may not reach those teenagers who have dropped out of school. How could these school-based programs be incorporated into a community programs and tailored so that the highest risk children will not be missed?

2. You conducted a study in 2006, along with some other researchers entitled, *Suicidal Ideation Among American Indian Youths*.

That study suggests that "increasing enculturation, enhancing self-esteem, and preventing drug use might decrease the likelihood of suicide ideation" and that it was "important to lessen the impact of negative life events and perceived discrimination perhaps through education and support networks."

What kind of evidence-based programs have been developed which might address this multitude of factors to prevent suicide ideation and attempts among American Indian children?

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